97TH CONGRESS
1st Session

SENATE

REPORT
No. 97-127

# HEALTH MAINTENANCE ORGANIZATIONS AMENDMENTS OF 1981

MAY 27, 1981.—Ordered to be printed

Filed under authority of the order of the Senate of MAY 21 (legislative day, APRIL 21, 1981

Mr. HATCH, from the Committee on Labor and Human Resources, submitted the following

## REPORT

together with

## ADDITIONAL VIEWS

[To accompany S. 1029]

The Committee on Labor and Human Resources, to which was referred the bill S. 1029 to amend Title XIII of the Public Health Service Act relating to health maintenance organizations, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

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## I. SUMMARY OF LEGISLATION

As approved by committee, S. 1029:

(1) Extends and substantially revises Title XIII of the Public Health Service Act dealing with development and qualification of Health Maintenance Organizations (HMO's).

(2) Provides an authorization of $15 million in the aggregate for FY82 through FY84 for grants and contracts under Title XIII to HMO's which had received support under this title before September 30, 1981.

(3) Extends the authority for the Secretary to make loans to qualified HMO's which received commitments prior to September 30th, 1981 by authorizing the addition of $35 million to the HMO loan fund.

(4) Extends the HMO management development program by authorizing an appropriation of $1 million for the fiscal year ending September 30, 1982 and for each of the two succeeding fiscal years.

(5) Extends, with modification, the process by which HMO's may become "federally qualified" and under which, under certain circumstances, employers may be required to offer federally qualified HMO's as an employee health care benefit.

## II. History of S. 1029, Including Hearings

S. 1029, a bill to amend the Public Health Service Act to revise provisions relating to Health Maintenance Organizations, was introduced on April 29, 1981 by Senator Hatch and was referred to the Committee on Labor and Human Resources.

At the May 6, 1981 Executive Session of the Committee on Labor and Human Resources, the Committee considered S. 1029. An amendment, adopted by voice vote without objection, was offered by Senator Hatch to: clarify language in S. 1029 dealing with the liability of HMO members for the payments of any fees which are the legal obligation of the HMO; make technical changes in the authorization for the HMO loan fund; and eliminate a provision that would relieve employers of the "dual choice" option under certain circumstances.

Senator Hatch also offered a second amendment, which was adopted without objection, that would: restore to S. 1029 the quality assurance provisions imposed on HMO's under existing law; restore, with modifications, the existing requirement that consumer members serve on the board of the HMO; and to restore to S. 1029 the existing definition of "basic benefits" and "supplemental benefits" which would affect the treatment of mental health, drug and alcohol, and family planning benefits.

The Committee also adopted the following amendments: by Senator Kennedy, to add authority for $15 million in the aggregate for FY82 through FY84 for grants and contracts for HMO's which received assistance under Title XIII prior to September 30, 1981; by Senator Kennedy, to reinstate the requirement that, at the penalty of losing certain funds under the Public Health Service Act, States be treated as employers for the purposes of Title XIII; by Senator Kennedy, to reinstate certain quality assurance related language dealing with fraud and abuse in administrative and managerial relations, and annual reports.

The Committee reported S. 1029 as amended without objection. The bill was reported to the Senate on May 15 and the report accompanying the bill was filed May 27th. The specific provisions are set forth in this report.

S. 1029 was adopted by the Committee after receiving comments from many individuals, organizations, and associations as well as from Richard S. Schweiker, Secretary, Department of Health and Human Services. A public hearing on S. 1029 was held on April 22, 1981 by the Committee on Labor and Human Resources.

The following witnesses testified on April 22nd:

Mr. James Dickson, Acting Assistant Secretary for Health, DHHS.

Mr. John O'Rourke, Acting Director, Office of HMO's, DHHS.

Mr. Boyd Thompson, Executive Vice President, American Association of Foundations for Medical Care.

Mr. James Doherty, Exec. Director, Group Health Association of America.

Mr. Thomas Pyles, Executive Director, Harvard Community Health Plan.

Dan Patterson, M.D., Intensive Service Division, Department of Psychiatry, Group Health Association of Washington.

Mr. Stanley Jones, Vice President, Blue Cross/Blue Shield Association.

Mr. Henry DiPrete, John Hancock Insurance Co., Vice President for Group Insurance Operations.

Mr. Davina C. Lane, Vice President, Insurance Co. of North America, Health Plan of California.

Mr. Arthur Young, Benefits Manager, Hewlett-Packard Co., Palo Alto, Calif.

Mr. Jan Ozga, Director, Health Care, U.S. Chamber of Commerce.

Ms. Ruth Stack, Exec. Director, Nat'l Assoc. of Employers on Health Care Alternatives.

Testimony for the hearing record was also received from the following organizations:

Group Health Association, Inc.

Washington Counsel/Medecine and Health.

Health Insurance Association of America.

Family Health Program.

## III. Background

The authority contained in Title XIII of the Public Health Service Act to provide Federal assistance for the development and operation of health maintenance organizations (HMOs) expires in fiscal year 1981. Title XIII also establishes standards for the Federal qualification of HMOs.

As used most generally, the term health maintenance organization describes an entity which provides specific health services to its members for a prepaid, fixed payment. In one respect, this arrangement is like a traditional health insurance program in the fee-for-service system. A monthly payment insures some portion of the costs of health services which a subscriber may incur during a period of time.

However, an HMO is different from the fee-for-service system and traditional health insurance programs in at least three respects. First, it is different in its approach to payment to providers of health care services. In an HMO, providers are at risk and are not reimbursed for each of the services they provide, as physicians in the fee-for-service system generally are.

Second, HMOs can be distinguished from a traditional health insurance program in the fee-for-service system by either providing directly or arranging to have provided those services specified in the HMO subscriber contract. A member of a Blue Cross/Blue Shield plan or other private health insurance plan in a fee-for-service arrangement does not have services provided by the plan. Rather, the member secures his own provider or providers whom the plan might then pay.

Finally, a member of an HMO most often is allowed to choose his own physician within the plan. However, the member is not allowed, except under extraordinary circumstances of medical emergency, to seek care from physicians or other providers outside the plan.

These aspects of the HMO concept are alleged to provide the HMO a capacity and a financial incentive to control the utilization of health services so as to reduce overall health care costs.

The term health maintenance organization was first advanced by Dr. Paul Ellwood in 1970, and was intended to include two basic HMO models: (1) the prepaid group practice model, and (2) the individual practice association or medical care foundation model. In both models, the HMO receives periodic payments of fixed amounts in return for the services it provides to HMO members.

Under the group practice model, however, most medical services are provided by physicians who are members of a group practice. Such physicians may be either employees of the HMO (in which case the HMO is often referred to as a staff model) or members of a separate entity which contracts with the HMO to provide medical services to HMO members. Physicians in these arrangements are paid in a variety of ways—the two most common being either by salary, or as a group where the HMO pays the group fixed payments per member each month.

Under the individual practice association or IPA model, physicians in a community, generally a county, or group of counties, contract with the HMO to provide medical services out of their private offices, which can be either solo or group practices. Physicians in IPAs are generally paid on a modified fee-for-service basis with retrospective adjustments based on performance by the HMO and the individual physician. In other words, the fewer expenses incurred by the HMO by the end of the year, the higher the income is likely to be for physicians at that time.

Group practice HMOs either own their own hospitals, such as is the case for most Kaiser Foundation Health Plans, or arrange for hospitalization for members at one or more community hospitals. The latter arrangement is the most common among group practice HMOs, and is the prevailing practice with individual practice association HMOs.

Because providers are at risk and are not reimbursed for each of the services they provide, HMOs are intuitively attractive as a means for cost control because they alter the usual economic incentives in medical care and give providers a stake in holding down costs. Evidence tends to support this theory, particularly when the response to HMO incentives is compared to the prevailing system of third-party reimbursement for providers. Studies have found that the total cost of medical care (i.e., premium plus out-of-pocket costs) for HMO en-

rollees is lower than it is for comparable people with conventional insurance coverages. The lower costs are clearest for enrollees in HMO group practices, where total costs are from 10 to 40 percent below the costs of conventional insurance enrollees.

Most of these cost differences have been found to be the result of hospitalization rates lower than those of conventionally insured populations. And these lower hospitalization rates are due almost entirely to lower admission rates; the average length of stay of a person in a hospital shows little difference in the HMO as opposed to the conventional arrangement.

For example, the last National HMO Census of Prepaid Health Plans noted, for 1979, the inpatient hospital utilization rate for all HMO plans was 412 days per 1,000 members per year. This compares to an average of about 730 days per 1,000 Blue Cross enrollees nationally in 1978.

In addition, physician visits per member per year for all HMO plans averaged 3.4, and total health plan encounters, including those with the HMOs' nurse practitioners or physicians assistants, per member per year for all plans averaged 4.5 in 1979. The national average was about 5 physician visits per person per year.

It should be noted that although there is substantial evidence of lower total costs for HMO enrollees, a recent study by Harold Luft, "Trends in Medical Care Costs: Do HMOs Lower the Rate for Growth?," indicates that there is little evidence that costs in HMOs are growing less rapidly than in the overall health care sector. This study and its findings suggest that HMOs may not have the solution to the problem of escalating medical costs within the prevailing third-party reimbursement system.

### TITLE XIII OF THE PUBLIC HEALTH SERVICE ACT

Title XIII of the Public Health Service Act was established when Congress enacted the Health Maintenance Organization Act of 1973, P.L. 93–222. The authority has been extended and revised twice—once in 1976 (P.L. 94–460) and again in 1978 (P.L. 95–559).

Among other things, Title XIII provides Federal support for the development and operation of HMOs. Grants and contracts are awarded for feasibility surveys and for the planning and initial development of HMOs or for the expansion of existing HMOs. Loan guarantees are also available for planning and initial development. In addition, loans and loan guarantees are available to HMOs for the first 5 years of their operation. Finally, another section in Title XIII provides loans and loan guarantees for the acquisition and construction of ambulatory health care facilities.

Title XIII also establishes standards for Federal qualification of HMOs. In order to be deemed qualified under Title XIII an HMO must provide certain specified basic health services. It must be organized in a certain fashion. The HMO must be fiscally sound, and the payment for enrollment in an HMO must be fixed under a community rating system.

Generally, under a community-rating system, the same premium is charged for the same benefits to all individuals or groups regardless

of age, sex composition, and cost experience of the insured. Under experience rating, on the other hand, premiums vary according to the cost experience of each group served. Members of some groups pay higher average premiums than members of other groups under this method. The use of experience rating has in practice tended to make health services most expensive for groups which are at highest risk and/or the highest utilizers of services, such as the aged or chronically ill. Under the community rating system of Title XIII, on the other hand, the HMO must price its services according to the experience in utilization which it has had with its entire enrolled membership.

In addition, Title XIII requires a qualified HMO which has provided comprehensive health services on a prepaid basis for at least 5 years or has an enrollment of at least 50,000 members to have an open enrollment period. During open enrollment, the HMO must accept individuals for membership without regard to preexisting illness, medical condition, or degree of disability.

There is an incentive for HMOs to seek qualified status under Title XIII and to meet these and other requirements. Once an HMO is qualified, it is able to take advantage of what is known as the dual choice requirement.

Under this provision of Title XIII, an employer which is subject to the minimum wage provisions of the Fair Labor Standards Act and which employs at least 25 persons is required to include in its health benefits plan, if it has one, that is, the option of joining a federally qualified HMO serving the area.

Finally, Title XIII authorizes support for technical assistance to developing and qualified HMOs. It also authorizes, as the result of an amendment enacted in 1978, support for a National Health Maintenance Organization Intern Program. The purpose of this program is to provide training for individuals to become administrators and medical directors of HMOs or to assume other managerial positions with these organizations.

Authorizations and appropriations for Title XIII are indicated in table 1.

TABLE 1.—BUDGET HISTORY FOR TITLE XIII

| | Authorizations[1] (millions) | Appropriations |
|---|---|---|
| Fiscal year 1979 | $31 | $23.0 million (grants).<br>$1.5 million (technical assistance).<br>$8.5 million (program support). |
| Fiscal year 1980 | 65 | $43.8 million (grants).<br>$1.5 million (technical assistance).<br>$9.2 million (program support). |
| Fiscal year 1981 | 68 | Appropriations bill not yet enacted. |

[1] For grants and contracts only.

## IV. Committee Views

The committee notes that as of January 1981, there were 242 HMOs in the country serving over 9 million people. In 1971, there had been only 39 HMOs serving 3.5 million people. Today there is at least one HMO in every metropolitan area in the country. A survey conducted

by InterStudy, a research organization in Minnesota, found operating HMOs to be distributed among the States, as follows, for July 1980:

TABLE 2.—OPERATING HMOs BY STATE, JULY 1980

| State | Number of plans | Membership July 1980 |
|---|---|---|
| Alabama | 1 | 2,696 |
| Arizona | 4 | 161,859 |
| California | 32 | 3,992,388 |
| Colorado | 6 | 198,478 |
| Connecticut | 7 | 74,011 |
| District of Columbia | 3 | 185,849 |
| Florida | 8 | 147,125 |
| Georgia | 2 | 8,912 |
| Hawaii | 2 | 147,218 |
| Idaho | 1 | 11,381 |
| Illinois | 12 | 238,048 |
| Indiana | 2 | 27,769 |
| Iowa | 1 | 6,200 |
| Kentucky | 4 | 33,620 |
| Louisiana | 3 | 23,682 |
| Maine | 2 | 4,527 |
| Maryland | 11 | 96,517 |
| Massachusetts | 10 | 173,731 |
| Michigan | 10 | 224,529 |
| Minnesota | 10 | 409,632 |
| Missouri | 5 | 111,233 |
| Nebraska | 2 | 16,885 |
| New Hampshire | 1 | 11,185 |
| New Jersey | 9 | 148,401 |
| New Mexico | 2 | 20,001 |
| New York | 12 | 971,402 |
| North Carolina | 1 | 33,914 |
| North Dakota | 1 | 2,803 |
| Ohio | 12 | 247,033 |
| Oregon | 8 | 334,236 |
| Pennsylvania | 10 | 137,317 |
| Rhode Island | 4 | 34,918 |
| South Carolina | 1 | 5,654 |
| Texas | 8 | 93,536 |
| Utah | 2 | 27,901 |
| Washington | 7 | 390,403 |
| West Virginia | 3 | 14,431 |
| Wisconsin | 16 | 392,047 |
| Guam | 1 | 21,925 |
| Total | 236 | 9,183,397 |

Of the 242 operational HMOs, 120 are federally qualified. These 120 HMOs have a membership of over 6 million persons.

As of the end of FY 1980, 617 grants had been awarded under Title XIII. These grants totaled $127.5 million.

By the end of FY 1980, 81 HMOs had received direct loans, totaling $168.6 million and 4 HMOs had received loan guarantees totaling $7.8 million.

Of the 120 currently qualified HMOs, 63 have received grants and loans, 19 have received grants only, 7 have received loans only, 3 have received loan guarantees, and 28 have received no assistance.

This growth in numbers of HMOs and their membership attests to the success of the Federal effort—an effort which, it should be pointed out, was intended at its original enactment to be only a limited demonstration project. The Federal effort has shown beyond any doubt that HMOs are a viable alternative to a traditional health insurance program in the fee-for-service system. While the committee does not believe that HMOs are a final answer for the Nation, they are, however, an essential component in a heterogeneous and competitive health care system.

Now that we can be assured that the HMO alternative is a viable one, the committee believes it is possible for the private sector to take full responsibility for the financing and development of these health care organizations. The committee also notes that, at a time when it is necessary to limit Federal expenditures in order to balance the Federal budget, it is critical that only the highest Federal priorities receive funding. If the private sector is playing an important role in HMO development today, we can recognize that a limited demonstration effort by the Federal Government has achieved its purposes.

And indeed the evidence indicates that the private sector has become significantly involved in HMO development. An examination of available data on developing HMOs reveals that there were 226 preoperational HMOs in the country as of February 1981. According to a survey conducted by InterStudy, 82 of these are federally funded HMOs and 144 are privately funded.

The committee's bill, therefore, proposes to continue Federal assistance only for those applicants which received funding under Title XIII prior to October 1, 1981. Specifically, the committee's bill extends the authorities for grants, contracts, and loan guarantees for the planning and initial development of HMOs which received assistance prior to October 1, 1981. It also continues for such applicants the authority for loans and loan guarantees for the initial costs of operation and allows the interest rates for such loans to vary from time to time so as to reflect changes in the rate of interest prevailing for marketable obligations of the U.S. with comparable maturities. The bill authorizes for such grants and contracts $15 million and for the HMO loan fund $35 million. However, the main purpose of the $35 million additional authorization for the loan fund is to insure the solvency of this loan fund. It is the committee's understanding that the loan fund has already incurred obligations that are approximately $30 million in excess of its projected resources. The committee intends that no further authorization be required to meet the obligations of the loan fund in addition to the $35 million authorized in the committee's bill. Thus, the committee directs the Department of Health and Human Services to exercise prudence in its management of the loan fund. Solvency of the loan fund must take priority over the granting of additional loans.

Given the significant level of private sector investment in HMOs, the committee believes that it is also important to increase incentives for further private involvement as well as to encourage innovation in HMO development. Since the establishment of the Title XIII authority in 1973, existing HMOs and potential developers of HMOs have argued that the various requirements specified in Title XIII for Federal qualification have produced barriers to development and have prevented HMOs from competing effectively with the traditional fee-for-service system which does not face such requirements or regulations.

For these reasons, the committee has adopted other provisions which will eliminate unnecessarily restrictive Federal requirements for HMO qualification so as to enable a greater variety of HMOs to be federally qualified. The committee's bill specifically repeals the

community rating and open enrollment requirements for Federal qualification.

The bill also adds a "contractual model" to the staff, group practice, and independent practice association models already delineated in Title XIII to be eligible for Federal qualification. Under the bill's contractual model, the HMO could contract with individual physicians to provide basic health services so long as these physicians agreed not to hold members of the HMO financially and personally liable for payment of services provided but not paid for by the HMO in the event of the HMO's default.

In addition, the committee's bill amends the separate corporate entity requirement of Title XIII to allow an HMO to be part of another corporate entity if that entity provides assurances satisfactory to the Secretary that the HMO will remain financially viable for the duration of its certification for Federal qualification. This requirement is not intended to disrupt any existing relationships. An organization may have the same Board of Directors for different legal entities that are HMOs provided the HMOs do not serve the same geographic areas.

HMOs, under the committee's bill, would also be required to assure that members would not be held liable for the costs incurred by the HMO. The HMO could either enter into "hold harmless" contracts with such hospitals, or secure default insurance for such protection, or maintain adequate financial reserves, or take such other measures as the Secretary considers appropriate for such purposes. This requirement would not apply in States where law already requires an HMO to take "hold harmless" measures to protect its members.

The committee believes that the requirements for Federal qualification should be less concerned with engineering the nature of HMOs and more concerned with insuring their viability as businesses that supply good services at a reasonable cost. Employers who are required to offer HMO plans and employees who choose to enroll in them should be assured that federally qualified HMOs will remain in business for the duration of their contracts. For these reasons, the committee's bill includes the revisions described above as well as the following changes.

The committee's bill requires that HMOs periodically demonstrate to the Department, but no more frequently than every 2 years, that they are in compliance with requirements specified for qualification. The committee intends that this process resemble accreditation and be paid for by the HMO. In addition, the committee's bill allows the Secretary to delegate to the States the responsibility for this accreditation but only to the extent he finds that a State is able and willing to do so. The committee intends that this periodic accreditation be a credible assessment of the HMOs without being onerous or expensive for them. The reviews should not be as elaborate as the initial qualification process. The reviews should entail minimal demands for documentation and written justification. The committee's bill extends the authority for the National Health Maintenance Organization Intern program. This program has expanded the pool of managerial expertise needed by HMOs. In addition, the authority for technical assistance to HMOs is continued by the committee's bill. For these two purposes,

the bill authorizes $1 million for each of the fiscal years 1982 through 1984.

Finally, although the committee reinserted provisions from existing law regarding administrative and managerial relations, the committee intends that the Department of Health and Human Services not use the authority granted it under these provisions arbitrarily, such as to force the resignations of individual HMO administrators. In addition, since it is a major purpose of these amendments to promote private investment, the committee instructs the Department of Health and Human Services to make every effort to be flexible in working with private companies that invest in federally qualified HMOs.

## V. Votes in Committee

Pursuant to Section 133(b) of the Legislative Reorganization Act of 1946, the following is a tabulation of votes cast in committee on S. 1029. S. 1029 was considered in open Executive Session on May 6, 1981 by the Committee on Labor and Human Resources.

Mr. Hatch moved the adoption of an amendment which would: require a federally qualified HMO to adopt at least one arrangement to protect its members from incurring liability for payment of any fees which are the legal obligation of the HMO; make technical changes in the authorization of appropriations for the HMO loan fund; and delete a requirement from S. 1029 which would relieve employers of the dual choice requirement under certain circumstances. This amendment was adopted by voice vote without objection.

Mr. Hatch also offered an amendment that would restore to the text of S. 1029, three provisions of the existing Title XIII HMO law dealing with: quality assurance provisions; with modifications, the requirement that consumers be represented on the boards of HMO's; and the "basic benefit" package and the "supplemental benefit" package. This amendment was adopted by voice vote.

Senator Kennedy moved the adoption of an amendment in the form of a substitute to S. 1029, which would more nearly resemble existing law than S. 1029. The motion was defeated by a tie vote of 8 to 8, as follows:

| YEAS | NAYS |
|---|---|
| Kennedy | Hatch |
| Randolph | Stafford |
| Williams | Quayle |
| Pell | Hawkins |
| Eagleton | Nickles |
| Riegle | Humphrey |
| Metzenbaum | Denton |
| Weicker | East |

Senator Kennedy moved the adoption of an amendment to provide $15 million in authorizations in the aggregate for FY82 through FY84 for grants and contracts under Title XIII for HMO's that received assistance prior to September 30, 1981. The amendment was adopted by a vote of 10 to 6 as follows:

| YEAS | NAYS |
|---|---|
| Stafford | Hatch |
| Hawkins | Quayle |
| Weicker | Nickles |
| Kennedy | Humphrey |
| Randolph | Denton |
| Williams | East |
| Pell | |
| Eagleton | |
| Riegle | |
| Metzenbaum | |

Mr. Kennedy moved the adoption of an amendment which would require that States, at the penalty of losing funds under the Public Health Service Act, be treated as "employers" for the purpose of the HMO dual choice option. The amendment was adopted by a vote of 9 to 7 as follows:

| YEAS | NAYS |
|---|---|
| Kennedy | Hatch |
| Randolph | Quayle |
| Williams | Hawkins |
| Pell | Nickles |
| Eagleton | Humphrey |
| Riegle | Denton |
| Metzenbaum | East |
| Stafford | |
| Weicker | |

Mr. Kennedy offered an amendment to reinstate existing provisions dealing with the requirement for federally qualified HMO's to maintain at least annually an open enrollment period. The motion was defeated by a tie vote of 8 to 8 as follows:

| YEAS | NAYS |
|---|---|
| Kennedy | Hatch |
| Randolph | Stafford |
| Williams | Quayle |
| Pell | Hawkins |
| Eagleton | Nickles |
| Riegle | Humphrey |
| Metzenbaum | Denton |
| Weicker | East |

Senator Kennedy moved the adoption of an amendment dealing with quality assurance which the Chairman agreed to accept in part and which was therefore adopted without objection.

Senator Hatch moved that S. 1029, as amended and containing a variety of additional technical amendments, be reported to the Senate. The motion carried by a vote of 16 to 0 as follows:

| YEAS | NAYS |
|---|---|
| Hatch | None |
| Stafford | |
| Quayle | |
| Hawkins | |
| Nickles | |
| Weicker | |
| Humphrey | |
| Denton | |
| East | |
| Kennedy | |
| Randolph | |
| Williams | |
| Pell | |
| Eagleton | |
| Riegle | |
| Metzenbaum | |

## VI. Cost Estimate

U.S. Congress,
Congressional Budget Office,
*Washington, D.C., May 21, 1981.*

Hon. Orrin G. Hatch,
*Chairman, Committee on Labor and Human Resources, U.S. Senate, Washington, D.C.*

Dear Mr. Chairman: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for S. 1029, a bill to amend title XIII of the Public Health Service Act relating to health maintenance organizations.

Should the Committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

Alice M. Rivlin,
*Director.*

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

May 21, 1981.

1. Bill number: S. 1029.
2. Bill title: A bill to amend title XIII of the Public Health Service Act relating to health maintenance organizations.
3. Bill status: As reported by the Senate Committee on Labor and Human Resources, May 15, 1981.
4. Bill purpose: The bill would extend the authorization for grants and contracts for health maintenance organizations for three years. The bill would also extend the authorization for continued regulation of health maintenance organizations and the authorization for the loan fund established under section 1307(e) for an additional three years.

5. Cost estimate:

[By fiscal years, in millions of dollars]

| | 1982 | 1983 | 1984 | 1985 | 1986 |
|---|---|---|---|---|---|
| Authorization levels: | | | | | |
| General provisions relating to loan guarantees and loans (1307(e)) | 35.0 | | | | |
| Continued regulation of health maintenance organizations (1312) | 1.0 | 1.0 | 1.0 | | |
| Grants and contracts | 15.0 | | | | |
| Total authorization levels | 51.0 | 1.0 | 1.0 | | |
| Estimated outlays: | | | | | |
| General provisions relating to loan guarantees and loans (1307(e)) | 18.0 | 8.0 | 6.0 | 3.0 | |
| Continued regulation of health maintenance organizations (1312) | .5 | .7 | .9 | .5 | 0.3 |
| Grants and contracts | 8.0 | 4.0 | 3.0 | | |
| Total estimated outlays | 26.5 | 12.7 | 9.9 | 3.5 | .3 |

The costs of this bill fall within function 550.

6. Basis for estimate: All authorization levels have been specified in the bill. The authorization of $15 million for grants and contracts covers all provisions of the bill except Sections 1312 and 1307(e) which are each specifically authorized at $1 million and $35 million, respectively. The $15 million authorization may only be spent on grants and contracts for those entities receiving a grant or contract under this title before fiscal year 1982. Additionally, no loan may be made or guaranteed after September 30, 1981, except to those entities receiving financial support under this title before this date.

Authorized amounts are assumed to be fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of appropriate recent program data.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Hinda Ripps.

10. Estimate approved by:

James L. Blum,
*Assistant Director for Budget Analysis.*

## VII. Regulatory Impact Statement

Pursuant to Section 602 of Senate Resolution 4 concerning the regulatory impact of proposed legislation, the Committee provided the following evaluation of the anticipated additional paperwork and other regulatory impact that would result from the implementation of S. 1029 which revises and extends the provisions of Title XIII of the Public Health Service Act dealing with Health Maintenance Organizations. In general, the goal of this bill is to reduce regulatory requirements and paperwork.

### (A) ESTIMATED NUMBER OF INDIVIDUALS AND BUSINESSES REGULATED BY GROUP OR CLASS

No new classification of individuals or businesses in the private sector would become subject to regulation as a result of this legisla-

tion. This bill continues existing requirements that employers of twenty-five or more employees, including states which employ twenty-five or more employees, must offer federally qualified HMO's located in their health service area.

(B) ECONOMIC IMPACT OF SUCH REGULATION ON INDIVIDUALS OR BUSINESSES

There exists an economic cost, small but unquantified, of the existing dual choice requirement imposed on employers and of a new requirement for HMO's to be requalified. The Committee believes these modest costs to be outweighed by the benefit to the public by the promotion of health maintenance organizations and the protection of employers and employees from unqualified HMO's.

(C) ADDITIONAL PAPERWORK, TIME AND COST

It is not anticipated that the implementation of this legislation will impose any additional paperwork, time or cost upon the private sector, other than the cost to HMO's of obtaining requalification at intervals which are not more frequent than every two years.

## VIII. Section-by-Section Analysis

Section 1. Provides that this Act may be cited as the "Health Maintenance Organization Amendments of 1981".

Section 2. Amends Title XIII of the Public Health Service Act by inserting a new text of the title as follows:

Section 1301(a). Defines the term "Health Maintenance Organization" as a legal entity providing basic and supplemental health services on a pre-paid basis and in conformity with certain other requirements.

Section 1301(b). Specifies that a Health Maintenance Organization shall provide basic and supplemental health services to its members, without limitations as to time or cost and provides exceptions and specifications to this requirement. Requires that the services of a physician which are provided as basic health service shall be provided through: members of the staff of the health maintenance organization, a medical group, an individual practice association, physicians or other health professionals who contracted with the HMO, or any combination of such staff, group, association or physicians under contract with the organization. Provides exceptions to this requirement and other basic requirements for a health maintenance organization.

Section 1301(c). Requires that each health maintenance organization shall: have a fiscally sound operation and adequate provision against risk of insolvency; have administrative and managerial arrangements satisfactory to the Secretary; be a separate corporate entity with a corporate board of directors except when certain conditions are met and unless such arrangements disrupt existing relationships; assume full financial risk on a prospective basis for the provision of basic health services except under certain limited exceptions; enroll members entitled to medical assistance under a state plan approved

under Title XIX of the Social Security Act; protect its members from incurring liability for payment of any fees which are the legal obligation of the HMO; not expell or refuse to re-enroll any member because of his health status or his requirements for health services; have consumer membership on its policy making body except when specified exceptions are met; provide meaningful procedures for resolving grievances between the HMO and its members; have an ongoing quality assurance program for its health services.

Section 1302(1). Defines the term "basic health services" to mean physician services, in-patient and out-patient hospital services, medically necessary emergency health services, short-term (not to exceed twenty visits) out-patient evaluative and crisis intervention mental health services, medical treatment and referral services for abuse of or addiction to alcohol and drugs, diagnostic laboratory and therapeutic radiologic services, home health services, and certain preventive health services which are enumerated. Provides a basis on which the Secretary, upon application of an HMO may determine that a health service is not a basic health service under this definition.

Section 1302(2). Defines the term "supplemental health services" to mean services of facilities for intermediate and long-term care, vision, dental and mental health services that are not included as a basic health service, longterm physical, medicine and rehabilitative services, the provision of prescription drugs, and other health services which have been approved by the Secretary for delivery as supplemental health services.

Section 1302(3). Defines the term "member" when used in connection with health maintenance organization.

Section 1302(4). Defines the term "medical group".

Section 1302(5). Defines the term "individual practice association".

Section 1302 A. Provides authority for the Secretary to make grants and contracts with public or non-profit private entities for projects for surveys or other activities to determine the feasibility of developing and operating or expanding the operation of health maintenance organizations and provides certain requirements, priorities, and limitations upon such assistance. Individual grants under this section may not exceed $75,000.

Secion 1303(a). Authorizes the Secretary to make grants and contracts for the establishment of health maintenance organizations or for the significant expansion of the membership of, or areas served by HMO's, and to guarantee to non-federal lenders payment of the principle of and the interest on loans for the establishment or expansion of HMO's.

Section 1303(b). Authorizes the Secretary to make grants and contracts for the initial development of HMO's and to guarantee to non-federal lenders the principle of and the interest on loans made to entities for the initial development of HMO's.

Section 1303(c). Requires applicants under this section to consult with local health planning agencies and medical societies and imposes certain other requirements.

Section 1303(d). Requires the Secretary to give priority under this section to applicants whose membership will be composed of not less than 30 percent who are members of a medically underserved population.

Section 1303 (e) through (k). Places additional restrictions upon the use and procedures for funds available under this section and assures that funds are available under this section to fund certain high priority applicants.

Section 1304. Authorizes the Secretary to make loans to HMO's to assist them in meeting their initial costs of operation during the first five years of their existence, to assist such HMO's in meeting their cost of operation which are attributable to a significant expansion in their membership or area served, or guarantee to non-federal lenders the payment of the principle of and the interest on loans made to non-profit private HMO's for the first two purposes. Limitations are placed on the amounts of money that may be loaned or guaranteed under this section. No loan may be made or guaranteed under this section after September 30, 1981 except to such entities that have first received financial support under this title before such date.

Section 1304 A. Authorizes the Secretary to: make loans for projects for the acquisition or construction of ambulatory health care facilities and equipment therein needed to federally qualify the HMO; or guarantee to non-federal lenders loans for such projects.

Section 1304B. Authorizes the Secretary to make grants and contracts to public or private non-profit entities for the purpose of demonstrating and evaluating the need for federal financial assistance to develop health maintenance organizations in areas that are not now adequately served by HMO's.

Section 1305(a). Requires that no loan or loan guarantee may be made under this title unless an application has been submitted to and approved by the Secretary.

Section 1305(b). Provides that the Secretary may not approve an application for a loan or loan guarantee under this title unless certain application requirements are met and assurances are provided.

Section 1305(c). Provides procedures by which an HMO which is denied fderally qualified status under Section 1309(d) may obtain reconsideration of such determination including, at the entities election, a fair hearing.

Section 1306. Provides that each recipient of a loan or loan guarantee under this title shall keep such records as the Secretary shall prescribe and allow reasonable access thereto for the purpose of audit and examination. Requires a full and complete report to the Secretary at the completion of any loan or loan guarantee period. Provides that entities which provide health services to defined populations on a pre-paid basis and which has members who are entitled to insurance benefits under Title XVIII of the Social Security Act or medical assistance under a State plan approved under Title XIX of such Act may be considered as a Health Maintenance Organization if it meets certain defined criteria.

Section 1307. Provides general provisions relating to loan guarantees and loans, including terms and conditions of such loans and loan guarantees, the authority of the Secretary to obtain recovery of any payments made, and requirements that the receiving grantee be fiscally sound.

Section 1307(d). Establishes in the Treasury a loan guarantee fund which shall be available to the Secretary without fiscal year limitation

to enable him to discharge his responsibilities under loan guarantees issued by him under this title.

Section 1307(e) Establishes in the Treasury a loan fund which shall be available to the Secretary without fiscal year limitation to enable him to make loans under this title.

Section 1307(f). Authorizes the Secretary to take such action as he deems appropriate to protect the interests of the United States in the event of a default of a loan made or guaranteed under this title.

Section 1307(g). Authorizes the Secretary to deposit in the miscellaneous receipts of the Treasury any monies available under the above two funds which are not needed to accomplish the purposes of them.

Section 1308(a). For the purposes of carrying out the health maintenance organization intern program established under Section 1312, they are authorized to be appropriated $1 million for the FY ending Setpember 30, 1982 and for each of the two succeeding fiscal years.

Section 1308(b). There is authorized to be appropriated to the loan fund established under Section 1307(e) $35 million in the aggregate for fiscal years ending after September 30, 1981.

Section 1308(c). Provides that: except as provided in Subsection (a) or Subsection (b), there are authorized to be appropriated for grants and contracts under this title, $15 million in the aggregate for the fiscal years ending September 30, 1982, September 30, 1983, and September 30, 1984. Funds may be obligated for a grant or contract only if the entity received a grant or contract under this title during or prior to the fiscal year ending September 30, 1981.

Section 1309(a). Requires each employer, including any state or political subdivision thereof, which employs not less than 25 employees, to offer to such employees a membership in a qualified health maintenance organization if a qualified HMO has a service area in which at least twenty five of such employees reside. Provides that where there is a collective bargaining representative, the employer shall provide to such representative the option of the HMO to accept or refuse.

Section 1309(b). Provides that if there is more than one qualified HMO in the area in which the employees reside and certain other conditions are met, the employer may be required to offer at least one of two different types of HMO's.

Section 1309(c). Provides that no employers should be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or contract.

Section 1309(d). Defines the term "qualified health maintenance organization" to mean an HMO under the terms of this title or an entity which proposes to become an HMO in which the Secretary determines will meet the requirements of this title, provided however, that every HMO must, at its own expense, demonstrate to the Secretary every two years, or such longer period as the Secretary may by regulation require, that such organization is qualified under this title.

Section 1309(e). Provides civil penalties to be assessed against any employer who knowingly does not comply with the requirements of the section, and provides opportunity for notice and hearing before such civil penalty is assessed.

Section 1309(f). Defines the term "employer" so as not to include the government of the United States, or the District of Columbia, or certain territories, states, political subdivisions thereof, the U.S. Postal Service, churches, conventions, asscciations of churches, and organizations described in I.R.S. Section 501(c)(3) provided such organizations meet certain conditions.

Section 1309(g). Provides opportunity for notice and hearing for any state found not to comply with this section prior to the revocation of any funds under the Public Health Service Act for failure to comply.

Section 1310. Provides that restrictive state laws and practices which prevent HMO's from organizing and providing services shall not apply to an entity which is an HMO qualified under this title.

Section 1311. Provides procedures by which the Secretary may withdraw the qualified status of an HMO under this title, and provides procedures for notice and opportunity for hearing for any HMO so affected. Permits the Secretary to delegate to a state the Secretary's responsibilities under this section with regard to withdrawing qualified status from an HMO.

Section 1312. Establishes a National Health Maintenance Organization Intern Program for the purposes of providing training to individuals to become administrators and medical directors of HMO's or to assume other managerial positions with HMO's. Authorizes the Secretary to provide technical assistance to entities receiving assistance under this title or seeking to become qualified HMO's.

Section 1313(a). Provides that each HMO shall report to the Secretary financial information necessary to demonstrate that the HMO has a fiscally sound operation and that the HMO has operated in accordance with acceptable financial practices including with regard to party in interest transactions.

Section 1313(b). Defines the term "party in interest".

Section 1313(c). Provides that each Health Maintenance Organization shall make the information reported under this section available to its enrollees upon reasonable request.

Section 1313(d). Provides that the Secretary shall, as he deems necessary, conduct an evaluation of "party in interest" transactions for the purpose of determining their adverse impact, if any, on the fiscal soundness and reasonableness of charges to the HMO with respect to which they transpired, and requires the Secretary to evaluate no less than five, no more than twenty HMO's reporting such transactions but in any case not less than one fourth of HMO's reporting any such actions.

Section 1313(e). Requires the Secretary to file an annual report with the Congress on the operation of this section.

Section 1313(f). Provides that nothing in this section shall be construed to confer upon the Secretary any authority to approve or disapprove the rates charged by any health maintenance organization.

Section 1313(g). Provides that any HMO failing to file with the Secretary the annual financial statement required under this section shall be ineligible for any federal assistance under this title and shall not be a qualified health maintenance organization for the purposes of Section 1309.

Section 1313(h). Provides that false statements or misrepresentations in any statement filed pursuant to this section shall be punishable as a felony and upon conviction an individual shall be fined not more than $25,000 nor imprisoned for not more than 5 years or both.

Section 1314. Provides that the Secretary may make loans and enter into contracts under this title only to such extent or in such amounts as are provided in appropriations acts.

Section 3 provides that this Act shall take effect on October 1, 1981.

## IX. Changes in Existing Law

In compliance with rule XXVI paragraph 12 of the Standard Rules of the Senate, the following provides a print of the statute or the part or section thereof to be amended or replaced (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

# PUBLIC HEALTH SERVICE ACT

## TITLE I— * * *

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## TITLE XIII—HEALTH MAINTENANCE ORGANIZATIONS

### REQUIREMENTS FOR HEALTH MAINTENANCE ORGANIZATIONS

Sec. 1301. (a) For purposes of this title, the term "health maintenance organization" means a legal entity which (1) provides basic and supplemental health services to its members in the manner prescribed by subsection (b), and (2) is organized and operated in the manner prescribed by subsection (c).

(b) A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this title, basic and supplemental health services to its members in the following manner:

(1) Each member is to be provided basic health services for a basic health services payment which (A) is to be paid on a periodic basis without regard to the dates health services (within the basic health services) are provided; (B) is fixed without regard to the frequency, extent, or kind of health service (within the basic health services) actually furnished; [(C) except in the case of basic health services provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education, is fixed under a community rating system; and (D)] (C) may be supplemented by additional nominal payments which may be required for the provision of specific services (within the basic health [services), except that such payments may not be required where or in such a manner that they serve (as determined under regulations of the Secretary) as a barrier to the delivery of health services.] *services*). Such additional nominal payments shall be fixed in accordance with

the regulations of the Secretary. A health maintenance organization may include a health service, defined as a supplemental health service by section 1302(2), in the basic health services provided its members for a basic health services payment described in the first sentence. [In the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 1310(d)) provided comprehensive health services on a prepaid basis, the requirement of clause (C) shall not apply to such entity until the expiration of the forty-eight month period beginning with the month following the month in which the entity became such a qualified health organization.] The requirements of this paragraph respecting the basic health services payment shall not apply to the provision of basic health services to a member for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or an insurance policy but only to the extent such benefits apply to such services. For the provision of such services for an illness or injury for which a member is entitled to benefits under such a law, the health maintenance organization may, if authorized by such law, charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law, the insurance carrier, employer, or other entity which under such law is to pay for the provision of such services or, to the extent that such member has been paid under such law for such services, such member. For the provision of such services for an illness or injury for which a member is entitled to benefits under an insurance policy, a health maintenance organization may charge or authorize the provider of such services to charge the insurance carrier under such policy or, to the extent that such member has been paid under such policy for such services, such member.

(2) For such payment or payments (hereinafter in this title referred to as "supplemental health services payments") as the health maintenance organization may require in addition to the basic health services payment, the organization may provide to each of its members any of the health services which are included in supplemental health services (as defined in section 1302(2)). [Supplemental health services payments which are fixed on a prepayment basis shall be fixed under a community rating system unless the supplemental health services payment is for a supplemental health service provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education, except that, in the case of an entity which before it became a qualified health maintenance organization (within the meaning of section 1310(d)) provided comprehensive health services on a prepaid basis, the requirement of this sentence shall not apply to such entity during the forty-eight month period beginning with the month following the month in which the entity became such a qualified health maintenance organization.]

(3)(A) Except as provided in subparagraph (B), the services of a physician which are provided as basic health services shall be provided through—

(i) members of the staff of the health maintenance organization,

(ii) a medical group (or groups),

(iii) an individual practice association (or associations),

[(iv) subject to subparagraph (C), physicians or other health professionals who have contracted with the health maintenance organization for the provision of such services, or]

*(iv) physicians or other health professionals who have contracted with the health maintenance organization for the provision of such services and who have agreed in such contract not to hold members of the organization personally liable for the payment of fees for such services, or*

(v) any combination of such staff, medical group (or groups), individual practice association (or associations) or physicians or other health professionals under contract with the organization.

[(B)(i) Subparagraph (A) does not apply to the provision of the services of a physician—

[(I) which the health maintenance organization determines, in conformity with regulations of the Secretary, are unusual or infrequently used, or

[(II) which are provided a member of the organization in a manner other than that prescribed by subparagraph (A) because of an emergency which made it medically necessary that the service be provided to the member before it could be provided in a manner prescribed by subparagraph (A).

[(ii) In a forty-eight-month period beginning after the month in which a health maintenance organization becomes a qualified health maintenance organization (within the meaning of section 1310(d)), the organization may provide the services of physicians through an entity which but for the requirement of section 1302(4)(C)(i) would be a medical group for the purposes of this title. After the expiration of such period, the organization may provide physician services through such an entity only if authorized by the Secretary in accordance with regulations which take into consideration the unusual circumstances of such entity.]

*(B) Subparagraph (A) does not apply to the provision of the services of a physician—*

*(i) which the health maintenance organization determines, in conformity with regulations of the Secretary, are unusual or infrequently used, or*

*(ii) which are provided a member of the organization in a manner other than that prescribed by subparagraph (A) because—*

*(I) of an emergency which made it medically necessary that the service be provided to the member before it could be provided in a manner prescribed by subparagraph (A); or*

*(II) the Secretary has provided a waiver of subparagraph (A) to the organization.*

[(C) After the expiration of the first four fiscal years of a health maintenance organization beginning after the month in which it became a qualified health maintenance organization (within the meaning of section 1310(d), the organization may not enter into contracts with physicians other than members of staff, medical groups, or individual practice associations if the amounts paid under such contracts for basic and supplemental health services provided by physicians exceed 15 per centum of the total estimated amount to be paid in such fiscal year by the health maintenance organization to physicians for the provision of basic and supplemental health services by physicians, or, if the health maintenance organization principally serves a rural area, 30 per centum of such amount, except that this subparagraph does not apply to the entering into contracts for the purchase of physician services through an entity which, but for the requirements of section 1302(4)(C)(i), would be a medical group for the purposes of this title.]

[(D)] *(C)* Contracts between a health maintenance organization and health professionals for the provision of basic and supplemental health services shall include such provisions as the Secretary may [require (including provisions requiring appropriate continuing education).] *require, but only to the extent that such requirements are designed to insure the delivery of quality health care services and sound fiscal management.*

[(E)] *(D)* For purposes of this paragraph the term "health professional" means physicians, dentists, nurses, podiatrists, optometrists, and such other individuals engaged in the delivery of health services as the Secretary may by regulation designate.

(4) Basic health services (and only such supplemental health services as members have contracted for) shall within the area served by the health maintenance organization be available and accessible to each of its members [promptly as appropriate and in a manner which assures continuity, and when medically necessary be available and accessible twenty-four hours a day and seven days a week.] *with reasonable promptness and in a manner which assures continuity, and when medically necessary be available and accessible twenty-four hours a day and seven days a week, except that a health service provided by a health maintenance organization whose service area is located wholly in a nonmetropolitan area may be made available only outside the service area if that health service is not a primary care service and if that service is not generally available within the service area.* A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing basic and supplemental health services other than through the organization if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition.

(5) To the extent that a natural disaster, war, riot, civil insurrection, or any other similar event not within the control of a health maintenance organization (as determined under regulations of the Secretary) results in the facilities, personnel, or financial resources of a health maintenance organization not being

available to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of paragraphs (1) through (4) of this subsection, such requirements only require the organization to make a good-faith effort to provide or arrange for the provision of such service within such limitation on its facilities, personnel, or resources.

(c) Each health maintenance organization shall—

(1) (A) have a fiscally sound operation and adequate provision against the risk of insolvency which is satisfactory to the Secretary, and (B) have administrative and managerial arrangements satisfactory to the Secretary;

*(2) be a corporate entity with a separate board of directors except that if a health maintenance organization is part of another corporate entity, such other entity must provide assurances, satisfactory to the Secretary, that the health maintenance organization will remain financially viable during the period such organization receives any benefit under this title including qualification under section 1309;*

[(2)] *(3)* assume full financial risk on a prospective basis for the provision of basic health services, except that a health maintenance organization may obtain insurance or make other arrangements (A) for the cost of providing to any member basic health services the aggregate value of which exceeds $5,000 in any year, (B) for the cost of basic health services provided to its members other than through the organization because medical necessity required their provision before they could be secured through the organization, and (C) for not more than 90 per centum of the amount by which its costs for any of its fiscal years exceed 115 per centum of its income for such fiscal year;

[(3) (A) enroll persons who are broadly representative of the various age, social, and income groups within the area it serves, except that in the case of a health maintenance organization which has a medically underserved population located (in whole or in part) in the area it serves, not more than 75 per centum of the members of that organization may be enrolled from the medically underserved population unless the area in which such population resides is also a rural area (as designated by the Secretary), and (B) carry out enrollment of members who are entitled to medical assistance under a State-plan approved under title XIX of the Social Security Act in accordance with procedures approved under regulations promulgated by the Secretary;

[(4) have an open enrollment period in accordance with the provisions of subsection (d);

[(5) not expel or refuse to re-enroll any member because of his health status or his requirements for health services;

[(6) (A) in the case of a private health maintenance organization, be organized in such a manner that assures that (i) at least one-third of the membership of the policymaking body of the health maintenance organization will be members of the organization, and (ii) there will be equitable representation on such body of members from medically underserved populations served by the organization, and (B) in the case of a public health mainte-

nance organization, have an advisory board to the policymaking body of the public entity operating the organization which board meets the requirements of clause (A) of this paragraph and to which may be delegated policymaking authority for the organization;

[(7) be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the health maintenance organization (including the medical group or groups and other health delivery entities providing health services for the organization) and the members of the organization;

[(8) have organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services which program (A) stresses health outcomes, and (B) provides review by physicians and other health professionals of the process followed in the provision of health services;

[(9) provide medical social services for its members and encourage and actively provide for its members health education services, education in the appropriate use of health services, and education in the contribution each member can make to the maintenance of his own health;

[(10) provide, or make arrangements for, continuing education for its health professional staff; and

[(11) provide, in accordance with regulations of the Secretary (including safeguards concerning the confidentiality of the doctor-patient relationship), an effective procedure for developing, compiling, evaluating, and reporting to the Secretary, statistics and other information (which the Secretary shall publish and disseminate on an annual basis and which the health maintenance organization shall disclose, in a manner acceptable to the Secretary, to its members and the general public) relating to (A) the cost of its operations, (B) the patterns of utilization of its services, (C) the availability, accessibility, and acceptability of its services, (D) to the extent practical, developments in the health status of its members, and (E) such other matters as the Secretary may require.

[(d)(1)(A) A health maintenance organization which—

[(i) has for at least 5 years provided comprehensive health services on a prepaid basis, or

[(ii) has an enrollment of at least 50,000 members,

shall have at least once during each fiscal year next following a fiscal year in which it did not have a financial deficit an open enrollment period (determined under subparagraph (B)) during which it shall accept individuals for membership in the order in which they apply for enrollment and, except as provided in paragraph (2), without regard to preexisting illness, medical condition, or degree of disability.

[(B) An open enrollment period for a health maintenance organization shall be the lesser of—

[(i) 30 days, or

[(ii) the number of days in which the organization enrolls a number of individuals at least equal to 3 percent of its total net increase in enrollment (if any) in the fiscal year preceding the fiscal year in which such period is held.

For the purpose of determining the total net increase in enrollment in a health maintenance organization, there shall not be included any individual who is enrolled in the organization through a group which had a contract for health care services with the health maintenance organization at the time that such health maintenance organization was determined to be a qualified health maintenance organization under section 1310.

[(2) Notwithstanding the requirements of paragraph (1) of health maintenance organization shall not be required to enroll individuals who are confined to an institution because of chronic illness, permanent injury, or other infirmity which would cause economic impairment to the health maintenance organization if such individual were enrolled.

[(3) A health maintenance organization may not be required to make the effective date of benefits for individuals enrolled under this subsection less than 90 days after the date of enrollment.

[(4) The Secretary may waive the requirements of this subsection for a health maintenance organization which demonstrates that compliance with the provisions of this subsection would jeopardize its economic viability in its service area.]

*(4) carry out enrollment of members who are entitled to medical assistance under a State plan approved under title XIX of the Social Security Act in accordance with procedures approved under regulations promulgated by the Secretary;*

*(5) adopt at least one of the following arrangements to protect its members from incurring liability for payment of any fees which are the legal obligation of such organization—*

*(A) a contractual arrangement with any hospital that is regularly used by the members of such organization prohibiting such hospital from holding any such member liable for payment of any fees which are the legal obligation of such organization;*

*(B) insolvency insurance, acceptable to the Secretary;*

*(C) adequate financial reserve, acceptable to the Secretary; and*

*(D) other arrangements, agreeable to the Secretary, to protect members,*

*except that the requirements of this paragraph shall not apply to a health maintenance organization if applicable State law provides the members of such organization with protection from liability for payment of any fees which are the legal obligation of such organization;*

*(6) not expel or refuse to reenroll any member because of his health status or his requirements for health services; and*

*(7)(A) except as provided in subparagraph (C), in the case of a private health maintenance organization, be organized in such a manner that assures that (i) at least one-third of the membership of the policymaking body of the health maintenance organization will be members of the organization, and (ii) there will be equitable*

*representation on such body of members from medically underserved populations served by the organization;*

*(B) in the case of a public health maintenance organization, have an advisory board to the policymaking body of the public entity operating the organization which board meets the requirements of subparagraph (A) of this paragraph and to which may be delegated policymaking authority for the organization; and*

*(C) in the case of a private health maintenance organization which is part of another corporate entity in accordance with paragraph (2), have an advisory board to the policymaking body of the corporate entity, which shall be comprised of health maintenance organization members;*

*(8) be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the health maintenance organization (including the medical group or groups and other health delivery entities providing health services for the organization) and the members of the organization; and*

*(9) have organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services which program (A) stresses health outcomes, and (B) provides review by physicians and other health professionals of the process followed in the provisions of health services.*

DEFINITIONS

SEC. 1302. For purposes of this title:

(1) The term "basic health services" means—

(A) physician services (including consultant and referral services by a physician);

(B) inpatient and outpatient hospital services;

(C) medically necessary emergency health serivces;

(D) short-term (not to exceed twenty visits), outpatient evaluative and crisis intervention mental health services;

(E) medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;

(F) diagnostic laboratory and diagnostic and therapeutic radiologic services;

(G) home health services; and

(H) preventive health services (including (i) immunizations, (ii) well-child care from birth, (iii) periodic health evaluations for adults, (iv) voluntary family planning services, (v) infertility services, and (vi) children's eye and ear examinations conducted to determine the need for vision and hearing correction).

Such term does not include a health service which the Secretary, upon application of a health maintenance organization, determines is unusual and infrequently provided and not necessary for the protection of individual health. The Secretary shall publish in the Federal Register each determination made by him under the preceding sentence. If a service of a physician described in the preceding sentence may also be provided under applicable State law by a dentist, optometrist, podiatrist, or other health care personnel a health main-

tenance organization may provide such service through a dentist, optometrist, podiatrist, or other health care personnel (as the case may be) licensed to provide such service. For purposes of this paragraph, the term "home health services" means health services provided at a member's home by health care personnel, as prescribed or directed by the responsible physician or other authority designated by the health maintenance organization. [A health maintenance organization is authorized, in connection with the prescription of drugs, to maintain, review, and evaluate (in accordance with regulations of the Secretary) a drug use profile of its members receiving such service, evaluate patterns of drug utilization to assure optimum drug therapy, and provide for instruction of its members and of health professionals in the use of prescription and non-prescription drugs.]

(2) The term "supplemental health services" means—

(A) services of facilities for intermediate and long-term care;

(B) vision care not included as a basic health service:

(C) dental services not included as a basic health service;

(D) mental health services not included as a basic health service under paragraph (1) (D);

(E) long-term physical medicine and rehabilitative services (including physical therapy);

(F) the provision of prescription drugs prescribed in the course of the provision by the health maintenance organization of a basic health service or a service described in the preceding subparagraphs of this paragraph; and

(G) other health services which are not included as basic health services and which have been approved by the Secretary for delivery as supplemental health services.

If a service of a physician described in the preceding sentence may also be provided under applicable State law by a dentist, optometrist, podiatrist, or other health care personnel, a health maintenance organization may provide such service through an optometrist, dentists, podiatrist, or other health care personnel (as the case may be) licensed to provide such service. [A health maintenance organization is authorized, in connection with the prescription or provision of prescription drugs, to maintain, review, and evaluate (in accordance with regulations of the Secretary) a drug use profile of its members receiving such services, evaluate patterns of drug utilization to assure optimum drug therapy, and provide for instruction of its members and of health professionals in the use of prescription and non-prescription drugs.]

(3) The term "member" when used in connection with a health maintenance organization means an individual who has entered into a contractual agreement, or on whose behalf a contractual arrangement has been entered into, with the organization under which the organization assumes the responsibility for the provision to such individual of basic health services and of such supplemental health services as may be contracted for.

(4) The term "medical group" means a partnership, association, or other group—

(A) which is composed of health professionals licensed to practice medicine or osteopathy and of such other licensed

health professionals (including dentists, optometrists, and podiatrists) as are necessary for the provision of health services for which the group is responsible;

(B) a majority of the members of which are licensed to practice medicine or osteopathy; and

(C) the members of which (i) as their principal professional activity engage in the coordinated practice of their profession and as a group responsibility have substantial responsibility for the delivery of health services to members of a health maintenance organization; (ii) pool their income from practice as members of the group and distribute it among themselves according to a prearranged salary or drawing account or other similar plan unrelated to the provision of specific health services; (iii) share medical and other records and substantial portions of major equipment and of professional, technical, and administrative staff; (iv) arrange for and encourage continuing education in the field of clinical medicine and related areas for the members of the group; and (v) establish an arrangement whereby a member's enrollment status is not known to the health professional who provides health services to the members.

(5) The term "individual practice association" means a partnership, corporation, association, or other legal entity which has entered into a services arrangement (or arrangements) with persons who are licensed to practice medicine, osteopathy, dentistry, podiatry, optometry, or other health profession in a State and a majority of whom are licensed to practice medicine or osteopathy. Such an arrangement shall provide—

(A) that such persons shall provide their professional services in accordance with a compensation arrangement established by the entity; and

(B) to the extent [feasible (i)] *feasible*, for the sharing by such persons of medical and other records, equipment, and professional, technical, and administrative [staff, and (ii) for the arrangement and encouragement of the continuing education of such persons in the field of clinical medicine and related areas.] *staff*.

[(6) The term "health systems agency" means an entity which is designated in accordance with section 1515 of this Act.

[(7) The term "medically underserved population" means the population of an urban or rural area designated by the Secretary as an area with a shortage of personal health services or a population group designated by the Secretary as having a shortage of such services. Such a designation may be made by the Secretary only after consideration of the comments (if any) of (A) each State health planning and development agency which covers (in whole or in part) such urban or rural area or the area in which such population group resides, and (B) each health systems agency designated for a health service area which covers (in whole or in part) such urban or rural area or the area in which such population group resides.

[(8) The term "community rating system" means a system of fixing rates of payments for health services. Under such a system rates of payments may be determined on a per-person or per-family basis and

may vary with the number of persons in a family, but except as otherwise authorized in the next sentence, such rates must be equivalent for all individuals and for all families of similar composition. The following differentials in rates of payments may be established under such system:

[(A) Nominal differentials in such rates may be established to reflect differences in marketing costs and the different administrative costs of collecting payments from the following categories of members:

[(i) Individual members (including their families).

[(ii) Small groups of members (as determined under regulations of the Secretary).

[(iii) Large groups of members (as determined under regulations of the Secretary).

[(B) Nominal differentials in such rates may be established to reflect the compositing of the rates of payment in a systematic manner to accommodate group purchasing practices of the various employers.

[(C) Differentials in such rates may be established for members enrolled in a health maintenance organization pursuant to a contract with a governmental authority under section 1079 or 1086 of the title 10, United States Code, or under any other governmental program (other than the health benefits program authorized by chapter 89 of title 5, United States Code) or any health benefits program for employees of States, political subdivision of States, and other public entities.

[(9) The term "non-metropolitan area" means an area no part of which is within an area designated as a standard metropolitan statistical area by the Office of Management and Budget and which does not contain a city whose population exceeds fifty thousand individuals.]

*GRANTS AND CONTRACTS FOR FEASIBILITY SURVEYS*

*SEC. 1302A. (a) The Secretary may make grants to and enter into contracts with public or nonprofit private entities for projects for surveys or other activities to determine the feasibility of developing and operating or expanding the operation of health maintenance organizations.*

*(b) An application for a grant or contract under this section shall contain—*

*(1) assurances satisfactory to the Secretary that, in conducting surveys or other activities with assistance under a grant or contract under this section, the applicant will (A) cooperate with each health systems agency designated for a health service area which covers (in whole or in part) the area for which the survey or other activity will be conducted, and (B) notify the medical society serving such area of such surveys or other activities; and*

*(2) such other information as the Secretary may by regulation prescribe.*

*(c) In considering applications for grants and contracts under this section, the Secretary shall give priority to an application which contains or is supported by assurances satisfactory to the Secretary that at the time the health maintenance organization for which such appli-*

*cation or proposal is submitted first becomes operational not less than 30 per centum of its members will be members of a medically underserved population.*

*(d) (1) Except as provided in paragraph (2), the following limitations apply with respect to grants and contracts made under this section:*

*(A) If a project has been assisted with a grant or contract under subsection (a), the Secretary may not make any other grant or enter into any other contract under this section for such project.*

*(B) Any project for which a grant is made or contract entered into must be completed within twelve months from the date the grant is made or contract entered into.*

*(2) The Secretary may make not more than one additional grant or enter into not more than one additional contract for a project for which a grant has previously been made or a contract previously entered into, and he may permit additional time (up to twelve months) for completion of the project if he determines that the additional grant or contract (as the case may be), or additional time, or both, is needed to adequately complete the project.*

*(e) The amount to be paid by the United States under a grant made, or contract entered into, under subsection (a) shall be determined by the Secretary, except that (1) the amount to be paid by the United States under any single grant or contract for any project may not exceed $75,000, and (2) the aggregate of the amounts to be paid by the United States for any project under such subsection under grants or contracts, or both, may not exceed the greater of (A) 90 per centum of the costs of such project (as determined under regulations of the Secretary), or (B) in the case of a project for a health maintenance organization which will serve a medically underserved population, such greater percentage (up to 100 per centum) of such costs as the Secretary may prescribe if he determines that the ceiling on the grants and contracts for such project should be determined by such greater percentage.*

*(f) Payments under grants under this section may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.*

*(g) Contracts may be entered into under this section without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).*

*(h) Payments under grants and contracts under this section shall be made from appropriations made under section 1309(a).*

*(i) Of the sums appropriated for any fiscal year under section 1309 (a) for grants and contracts under this section, not less than 20 per centum shall be set aside and obligated in such fiscal year for projects (1) to determine the feasibility of developing and operating or expanding the operation of health maintenance organizations which the Secretary determines may reasonably be expected to have after their development or expansion not less than 66 per centum of their membership drawn from residents of nonmetropolitan areas, and (2) the applications for which meet the requirements of this title for approval. Sums set aside in any fiscal year for projects described in the preceding sentence but not obligated in such fiscal year for grants and contracts under this section because of a lack of applicants for projects meeting*

*the requirements of such sentence shall remain available for obligation under this section in the succeeding fiscal year for any project, with priority being given to projects described in clause (1) of such sentence.*

[GRANTS AND CONTRACTS FOR FEASIBILITY SURVEYS

[SEC. 1303. (a) The Secretary may make grants to and enter into contracts with public or nonprofit private entities for projects for surveys or other activities to determine the feasibility of developing and operating or expanding the operation of health maintenance organizations.

[(b) An application for a grant or contract under this section shall contain—

[(1) assurance satisfactory to the Secretary that, in conducting surveys or other activities with assistance under a grant or contract under this section, the applicant will (A) cooperate with each health systems agency designated for a health service area which covers (in whole or in part) the area for which the survey or other activity will be conducted, and (b) notify the medical society serving such area of such surveys or other activities; and

[(2) such other information as the Secretary may by regulation prescribe.

[(c) In considering applications for grants and contracts under this section, the Secretary shall give priority to an application which contains or is supported by assurances satisfactory to the Secretary that at the time the health maintenance organization for which such application or proposal is submitted first becomes operational not less than 30 per centum of its members will be members of a medically underserved population.

[(d)(1) Except as provided in paragraph (2), the following limitations apply with respect to grants and contracts made under this section:

[(A) If a project has been assisted with a grant or contract under subsection (a), the Secretary may not make any other grant or enter into any other contract under this section for such project.

[(B) Any project for which a grant is made or contract entered into must be completed wtihin twelve months from the date the grant is made or contract entered into.

[(2) The Secretary may make not more than one additional grant or enter into not more than one additional contract for a project for which a grant has previously been made or a contract previously entered into, and he may permit additional time (up to twelve months) for completion of the project if he determines that the additional grant or contract (as the case may be), or additional time, or both, is needed to adequately complete the project.

[(e) The amount to be paid by the United States under a grant made, or contract entered into, under subsection (a) shall be determined by the Secretary, except that (1) the amount to be paid by the United States under any single grant or contract for any project may not exceed $75,000, and (2) the aggregate of the amounts to be paid by the United States for any project under such subsection under grants or contracts, or both, may not exceed the greater of

(A) 90 per centum of the costs of such project (as determined under regulations of the Secretary), or (B) in the case of a project for a health maintenance organization which will serve a medically underserved population, such greater percentage (up to 100 per centum) of such costs as the Secretary may prescribe if he determines that the ceiling on the grants and contracts for such project should be determined by such greater percentage.

[(f) Payments under grants under this section may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.

[(g) Contracts may be entered into under this section without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

[(h) Payments under grants and contracts under this section shall be made from appropriations made under section 1309(a).

[(i) Of the sums appropriated for any fiscal year under section 1309(a) for grants and contracts under this section, not less than 20 per centum shall be set aside and obligated in such fiscal year for projects (1) to determine the feasibility of developing and operating or expanding the operation of health maintenance organizations which the Secretary determines may reasonably be expected to have after their development or expansion not less than 66 per centum of their membership drawn from residents of non-metropolitan areas, and (2) the applications for which meet the requirements of this title for approval. Sums set aside in any fiscal year for projects described in the preceding sentence but not obligated in such fiscal year for grants and contracts under this section because of a lack of applicants for projects meeting the requirements of such sentence shall remain available for obligation under this section in the succeeding fiscal year for any project, with priority being given to projects described in clause (1) of such sentence.]

GRANTS, CONTRACTS, AND LOAN GUARANTEES FOR PLANNING AND FOR INITIAL DEVELOPMENT COSTS

[SEC. 1304.] *SEC. 1303.* (a) The Secretary may—

(1) make grants to and enter into contracts with public or nonprofit private entities for planning projects for the establishment of health maintenance organizations or for the significant expansion of the membership of, or areas served by, health maintenance organizations; and

(2) guarantee to non-Federal lenders payment of the principal and the interest on loans made to—

(A) nonprofit private entities for planning projects for the establishment or expansion of health maintenance organizations, or

(B) other private entities for such projects for health maintenance organizations which will serve medically underserved populations.

Planning projects assisted under this subsection shall include development of plans for the marketing of the services of the health maintenance organization.

(b) (1) The Secretary may—

(A) make grants to and enter into contracts with public or nonprofit private entities for projects for the initial development of health maintenance organizations; and

(B) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to—

(i) nonprofit private entities for projects for the initial development of health maintenance organizations, or

(ii) other private entities for such projects for health maintenance organizations which will serve medically underserved populations.

(2) For purposes of this section, the term "initial development" when used to describe a project for which assistance is authorized by this subsection means the establishment of a health maintenance organization, the expansion of the services of a health maintenance organization, or the significant expansion of the membership of, or the area served by, a health maintenance organization. Funds under grants and contracts under this subsection and under loans guaranteed under this subsection may only be utilized for such purposes as the Secretary may prsecribe in regulations. Such purposes may include (A) the implementation of an enrollment campaign for such an organization, (B) the detailed design of and arrangements for the health services to be provided by such an organization, (C) the development of administrative and internal organizational arrangements, including fiscal control and fund accounting procedures, and the development of a capital financing program, (D) the recruitment of personnel who will engage in practice principally for the health maintenance organization and the conduct of training activities for such personnel, and (E) the payment of architects' and engineers' fees.

(3) A grant or contract under this subsection may only be made or entered into for initial development costs incurred in a period not to exceed three years from the first day of the first month in which such grant or contract is made or entered into. A loan guarantee under this subsection may only be made for a loan (or loans) for such costs incurred in a period not to exceed three years.

(4) A health maintenance organization which is a qualified health maintenance organization within the meaning of section 1310(d) may receive, in accordance with paragraph (1), a grant, contract, or loan guarantee for the expansion of its services or the significant expansion of its membership or the area served by it.

(c) (1) An application for a grant, contract, or loan guarantee under subsection (a) for a planning project shall contain assurances satisfactory to the Secretary that in carrying out the planning project for which the grant, contract, or loan guarantee is sought, the applicant will (A) cooperate with each health systems agency designated for a health service area which covers (in whole or in part) the area proposed to be served by the health maintenance organization for which the planning project will be conducted, and (B) notify the medical society serving such area of the planning project.

(2) If the Secretary makes a grant or loan guarantee or enters into a contract under subsection (a) for a planning project for a health maintenance organization, he may, within the period in which

the planning project must be completed, make a grant or loan guarantee or enter into a contract under subsection (b) for the initial development of that health maintenance organization; but no grant or loan guarantee may be made or contract entered into under subsection (b) for initial development of a health maintenance organization unless the Secretary determines that (A) sufficient planning for its establishment or expansion (as the case may be) has been conducted by the applicant for the grant, contract, or loan guarantee, and (B) the feasibility of establishing and operating, or of expanding, the health maintenance organization has been established by the applicant.

(d) In considering applications for grants and contracts under this section, the Secretary shall give priority to an application which contains or is supported by assurances satisfactory to the Secretary that at the time the health maintenance organization for which such application is submitted first becomes operational not less than 30 per centum of its members will be members of a medically underserved population. In considering applications for loan guarantees under this section, the Secretary shall give special consideration to applications for projects for health maintenance organizations which will serve medically underserved populations.

(e) (1) Except as provided in paragraph (2), the following limitations apply with respect to grants, loan guarantees, and contracts made under subsection (a) of this section:

(A) If a planning project has been assisted with grant, loan guarantee, or contract under subsection (a), the Secretary may not make any other planning grant or loan guarantee or enter into any other planning contract for such project under this section.

(B) Any project for which a grant or loan guarantee is made or contract entered into must be completed within twelve months from the date the grant or loan guarantee is made or contract entered into.

(2) The Secretary may not make more than one additional grant or loan guarantee or enter into not more than one additional contract for a planning project for which a grant or loan guarantee has previously been made or a contract previously entered into, and he may permit additional time (up to twelve months) for completion of the project if he determines that the additional grant, loan guarantee, or contract (as the case may be), or additional time, or both, is needed to adequately complete the project.

(f) (1) The amount to be paid by the United States under a grant made, or contract entered into, under subsection (a) for a planning project, and (except as provided in paragraph (3) of this subsection) the amount of principal of a loan for a planning project which may be guaranteed under such subsection, shall be determined by the Secretary, except that (A) the amount to be paid by the United States under any single grant or contract, and the amount of principal of any single loan guaranteed under such subsection, may not exceed $200,000, and (B) the aggregate of the amounts to be paid for any project by the United States under grants or contracts, or both, under such subsection, and the aggregate amount of principal of loans guaranteed under such subsection for any project, may not exceed the greater of

(i) 90 per centum of the cost of such project (as determined under regulations of the Secretary), or (ii) int he case of a project for a health maintenance organization which will serve a medically underserved population, such greater percentage (up ot 100 per centum) of such cost as the Secretary may prescribe if he determines that the ceiling on the grants, contracts, and loan guarantees (or any combination thereof) for such project should be determined by such greater percentage.

(2) Except as provided in paragraph (3), the amount to be paid by the United States under a grant made, or contract entered into, under subsection (b) for an initial development project, and the amount of principal of a loan for an initial development project which may be guaranteed under such subsection, shall be determined by the Secretary; except that the amounts to be paid by the United States for any initial development project under grants or contracts, or both, under such subsection, and the aggregate amount of principal of loans guaranteed under such subsection for any project, may not exceed the lesser of—

(A) $1,000,000 through September 30, 1979, and $2,000,000 thereafter, or

(B) an amount equal to the greater of (i) 90 per centum of the cost of such project (as determined under regulations of the Secretary), or (ii) in the case of a project for a health maintenance organization which will serve a medically underserved population, such greater percentage (up to 100 per centum) of such cost as the Secretary may prescribe if he determines that the ceiling on the grants, contracts, and loan guarantees (or any combination thereof) for such project should be determined by such greater percentage.

(3) The cumulative total of grants made to, contracts entered into with, and principal of loans guaranteed for, a health maintenance organization under subsection (b) of this section may not exceed $1,000,000 through September 30, 1979, or $2,000,000 thereafter. The cumulative total of the principal of the loans outstanding at any time with respect to which guarantees have been issued under this section may not exceed such limitations as may be specified in appropriation Acts.

(g) Payments under grants under this section may be made in advance or by way of reimbursement and at such intervals and on such conditions as the Secretary finds necessary.

(h) Contracts may be entered into under this section without regard to sections 3648 and 3709 of the Revised Statutes (31 U.S.C. 529; 41 U.S.C. 5).

(i) Payments under grants and contracts under this section shall be made from appropriations under section 1309(a).

(j) Loan guarantees under subsection (a)(2) for planning projects and loan guarantees under subsection (b)(1)(B) for initial development projects may be made through the fiscal year ending September 30, [1981.] *1984.*

(k)(1) Of the sums appropriated for any fiscal year under section 1309(a) for grants and contracts under subsection (a) of this section, not less than 20 per centum shall be set aside and obligated in such

fiscal year for projects (A) to plan the establishment or expansion of health maintenance organizations which the Secretary determines may reasonably be expected to have after their establishment or expansion not less than 66 per centum of their membership drawn from residents of non-metropolitan areas, and (B) the applications for which meet the requirements of this title for approval. Sums set aside in any fiscal year for projects described in the preceding sentence but not obligated in such fiscal year for grants and contracts under subsection (a) of this section because of a lack of applicants for projects meeting the requirements of such sentence shall remain available for obligation under such subsection in the succeeding fiscal year for any project, with priority being given to projects described in clause (A) of such sentence.

(2) Of the sums appropriated for any fiscal year under section 1309(a) for grants and contracts under subsection (b) of this section, not less than 20 per centum shall be set aside and obligated in such fiscal year for projects (A) for the initial development of health maintenance organizations which the Secretary determines may reasonably be expected to have after their initial development not less than 66 per centum of their membership drawn from residents of non-metropolitan areas, and (B) the applications for which meet the requirements of this title for approval. Sums set aside in any fiscal year for projects described in the preceding sentence but not obligated in such fiscal year for grants and contracts under subsection (b) of this section because of a lack of applicants for projects meeting the requirements of such sentence shall remain available for obligation under such subsection in the succeeding fiscal year for any project, with priority being given to projects described in clause (A) of such sentence.

LOANS AND LOAN GUARANTEES FOR INITIAL COSTS OF OPERATION

[SEC. 1304] *SEC. 1304.* (a) The Secretary may—

(1) make loans to public or nonprofit private health maintenance organizations to assist them in meeting the amount by which their costs of operation during a period not to exceed the first sixty months of their operation exceed their revenues in that period;

(2) make loans to public or nonprofit private health maintenance organizations to assist them in meeting the amount by which their costs of operation, which the Secretary determines are attributable to significant expansion in their membership or area served and which are incurred during a period not to exceed the first sixty months of their operation after such expansion, exceed their revenues in that period which the Secretary determines are attributable to such expansion; and

[(3) guarantee to non-Federal lenders payment of the principal of and the interest on loans made to—

[(A) nonprofit private health maintenance organizations for the amounts referred to in paragraph (1) or (2), or

[(B) other private health maintenance organizations for such amounts but only if the health maintenance organization will serve a medically underserved population.

*(3) guarantee to non-Federal lenders and to the Federal Financing Bank payment of the principal of and the interest on loans made to nonprofit private health maintenance organizations for the amounts referred to in paragraph (1) or (2).*

No loan or loan guarantee may be made under this subsection for the costs of operation of a health maintenance organization unless the Secretary determines that the organization has made all reasonable attempts to meet such costs.

(b)(1) Except as provided in paragraph (2), the aggregate amount of principal of loans made or guaranteed, or both, under this section for a health maintenance organization may not exceed $2,500,000 (or $4,500,000 if the Secretary makes a written determination that such loans or loan guarantees are necessary to preserve the fiscally sound operation of the health maintenance organization and to protect against the risk of insolvency of the health maintenance organization and, within 30 days of the making of such loans or loan guarantees, furnishes the Committee on *Labor and* Human Resources of the Senate and the Committee on [Interstate and Foreign] *Energy and* Commerce of the House of Representatives with written notification of the making of the loans or loan guarantees [and a copy of the written determination made with respect to the loans or loan guarantees] and the reasons for the determination) through September 30, 1979, and $4,500,000 thereafter. In any twelve-month period the amount disbursed to a health maintenance organization under this section (either directly by the Secretary or by an escrow agent under the terms of an escrow agreement or by a lender under a loan guaranteed under this section) may not exceed $1,000,000 (or $2,000,000 if the Secretary makes a written determination that such disbursements are necessary to preserve the fiscally sound operation of the health maintenance organization and protect against the risk of insolvency of the health maintenance organization and, within 30 days of such disbursement, furnishes the Committee on *Labor and* Human Resources of the Senate and the Committee on [Interstate and Foreign] *Energy and* Commerce of the House of Representatives with written notification of the making of the disbursement and a copy of the written determination made with respect to it and the reasons for the determination) through September 30, 1979, and $2,000,000 thereafter.

(2) The cumulative total of the principal of the loans outstanding at any time which have been directly made or with respect to which guarantees have been issued under subsection (a) may not exceed such limitations as may be specified in appropriation Acts.

(c) Loans under this section shall be made from the fund established under section [1308(e).] *1307(e).*

(d) No loan may be made or guaranteed under this section after September 30, [1981.] *1981, except to such entities as first received financial support under this title before such date.*

[(e) Of the sums used for loans under this section in any fiscal year from the loan fund established under section 1308(e), not less than 20 per centum shall be used for loans for projects (1) for the initial operation of health maintenance organizations which the Secretary determines have not less than 66 per centum of their membership drawn from residents of nonmetropolitan areas, and (2) the applications for which meet the requirements of this title for approval.

[(f) In considering applications for loan guarantees under this section, the Secretary shall give special consideration to applications for health maintenance organizations which will serve medically underserved populations.]

*AMBULATORY HEALTH CARE FACILITIES*

*SEC. 1304A. (a) The Secretary may—*

*(1) make loans, from the fund established under section 1308 (e), to public and nonprofit private health maintenance organizations for projects for the acquisition or construction of ambulatory health care facilities and for the acquisition of equipment for facilities acquired or constructed under a loan made under this paragraph; and*

*(2) guarantee to—*

*(A) non-Federal lenders for their loans to nonprofit private health maintenance organizations for projects described in paragraph (1) and to private health maintenance organizations for such projects which will serve medically underserved populations, and*

*(5) the Federal Financing Bank for its loans to nonprofit private health maintenance organizations for projects described in paragraph (1) and to private health maintenance organizations for such projects which will serve medically underserved populations,*

*the payment of principal and interest on such loans.*

*(b) (1) Except as provided in paragraph (2), the aggregate amount of principal of loans made or guaranteed, or both, under subsection (a) for an ambulatory health care facility may not exceed $2,500,000.*

*(2) The cumulative total of the principal of the loans outstanding at any time which have been directly made or with respect to which guarantees have been issued under subsection (a) may not exceed such limitations as may be specified in appropriation Acts.*

*(3) The authority of the Secretary to make loans under subsection (a) shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance in appropriation Acts.*

*(c) For purposes of this section—*

*(1) the term "ambulatory health care facility" means a health care facility for the provision of diagnosis, treatment, and prevention services to ambulatory patients; and*

*(2) the term "construction" means the (A) construction of new facilities, (B) alterations, expansion, remodeling, replacement, and renovation of existing facilities, (C) cost of offsite improvements in connection with an activity described in clause (A) or (B), and (D) cost of the acquisition of land in connection with an activity described in clause (A), (B), or (C).*

*GRANTS AND CONTRACTS FOR DEMONSTRATION AND EVALUATION OF THE NEED FOR HEALTH MAINTENANCE ORGANIZATIONS*

*SEC. 1304B. (a) The Secretary may make grants to and enter into contracts with public or private nonprofit entities for the purpose of demonstrating and evaluating the need for Federal financial assistance to develop health maintenance organizations in areas that are*

*not now adequately served by health maintenance organizations. Funds made available under this section may be used for—*

*(1) projects for surveys or other activities to determining the feasibility of developing and operating health maintenance organizations;*

*(2) planning projects for the establishment of health maintenance organizations; and*

*(3) the initial development of health maintenance organizations.*

*(b) An application for a grant or contract under this section shall contain—*

*(1) information concerning the extent to which the area to be served is being served by any existing health maintenance organization;*

*(2) information concerning the need for Federal financial assistance for projects to determine the feasibility of health maintenance organizations, to plan for the establishment of health maintenance organizations, or to develop health maintenance organizations; and*

*(3) such other information as the Secretary may by regulation prescribe.*

*(c) In considering applications for grants and contracts under this section, the Secretary shall give priority to areas that are not served by health maintenance organizations or that are inadequately served by health maintenance organizations, and shall to the maximum extent practicable, attempt to identify comparable areas that are not served or are inadequately served by health maintenance organizations for the purpose of comparing and evaluating the development of health maintenance organizations in underserved areas where Federal assistance is provided as compared with development of health maintenance organizations in underserved areas where no Federal assistance is provided.*

*(d) For the purpose of conducting the demonstration projects under this section, the Secretary may waive compliance with any of the requirements of section 1301 to the extent and for such period of time as is necessary to accomplish the purposes of this section.*

*(e) By January 1, 1984, the Secretary shall prepare and transmit to Congress a report evaluating the need for and efficacy of Federal financial assistance for the development of health maintenance organizations. The Secretary shall evaluate the projects carried out under this section in preparing such report and may include in such report any other information that the Secretary determines appropriate.*

[LOANS AND LOAN GUARANTEES FOR ACQUISITION AND CONSTRUCTION OF AMBULATORY HEALTH CARE FACILITIES

[SEC. 1305A. (a) The Secretary may—

[(1) make loans, from the fund established under section 1308(e), to public and nonprofit private health maintenance organizations for projects for the acquisition or construction of ambulatory health care facilities and for the acquisition of

equipment for facilities acquired or constructed under a loan made under this paragraph; and

[(2) guarantee to—

[(A) non-Federal lenders for their loans to nonprofit private health maintenance organizations for projects described in paragraph (1) and to private health maintenance organizations for such projects which will serve medically underserved populations, and

[(B) the Federal Financing Bank for its loans to nonprofit private health maintenance organizations for projects described in paragraph (1) and to private health maintenance organizations for such projects which will serve medically underserved populations,

the payment of principal and interest on such loans.

[(b)(1) Except as provided in paragraph (2), the aggregate amount of principal of loans made or guaranteed, or both, under subsection (a) for an ambulatory health care facility may not exceed $2,500,000.

[(2) The cumulative total of the principal of the loans outstanding at any time which have been directly made or with respect to which guarantees have been issued under subsection (a) may not exceed such limitations as may be specified in appropriation Acts.

[(3) The authority of the Secretary to make loans under subsection (a) shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance in appropriation Acts.

[(c) For purposes of this section.

[(1) the term "ambulatory health care facility" means a health care facility for the provision of diagnostic treatment, and prevention services to ambulatory patients; and

[(2) the term "construction" means the (A) construction of new facilities, (B) alterations, expansion, remodeling, replacement, and renovation of existing facilities, (C) cost of offsite improvements in connection with an activity described in clause (A) or (B), and (D) cost of the acquisition of land in connection with an activity described in clause (A), (B), or (C).]

APPLICATION REQUIREMENTS

[SEC. 1306.] *SEC. 1305.* (a) No [grant, contract, loan,] *loan* or loan guarantee may be made under this title unless an application therefor has been submitted to and approved by the Secretary.

(b) The Secretary may not approve an application for a [grant, contract, loan,] *loan* or loan guarantee under this title unless—

[(1) in the case of an application for assistance under section 1303 or 1304, such application meets the application requirements of such section and in the case of an application for a loan or loan guarantee, such application meets the requirements of section 1308;

[(2) in the case of an application for assistance under section 1304, 1305, or 1035A, he determines that the applicant making the application would not be able to complete the project or undertaking for which the application is submitted without the assistance applied for;

[(3) the application contains satisfactory specification of the existing or anticipated (A) population group or groups to be served by the proposed or existing health maintenance organization described in the application, (B) membership of such organization, (C) methods, terms, and periods of the enrollment of members of such organization, (D) estimated costs per member of the health and educational services to be provided by such organization and the nature of such costs, (E) sources of professional services for such organization, and organizational arrangements of such organization for providing health and educational services, (F) organizational arrangements of such organization for an ongoing quality assurance program in conformity with the requirements of section 1301(c), (G) sources of prepayment and other forms of payment for the services to be provided by such organization, (H) facilities, and additional capital investments and sources of financing therefor, available to such organization to provide the level and scope of services proposed, (I) administrative, managerial, and financial arrangements and capabilities of such organization, (J) role for members in the planning and policymaking for such organization, (K) grievance procedures for members of such organization, and (L) evaluations of the support for and acceptance of such organization by the population to be served, the sources of operating support, and the professional groups to be involved or affected thereby;

[(4) contains or is supported by assurances satisfactory to the Secretary that the applicant making the application will, in accordance with such criteria as the Secretary shall by regulation prescribe, enroll, and maintain an enrollment of the maximum number of members that is available and potential resources (as determined under regulations of the Secretary) will enable it to effectively serve;

[(5) each health systems agency designated for a health service area which covers (in whole or in part) the area to be served by the health maintenance organization for which such application is submitted;

[(6) in the case of an application made for a project which previously received a grant, contract, loan, or loan guarantee under this title, such application contains or is supported by assurances satisfactory to the Secretary that the applicant making the application has the financial capability to adequately carry out the purposes of such project and has developed and operated such project in accordance with the requirements of this title and with the plans contained in previous applications for such assistance;

[(7) the application contains such assurances as the Secretary may require respecting the intent and the ability of the applicant to meet the requirements of paragraphs (1) and (2) of section 1301(b) respecting the fixing of basic health services payments and supplemental health services payments under a community rating system; and

[(8) the application is submitted in such form and manner,

and contains such additional information, as the Secretary shall prescribe in regulations.

An organization making multiple applications for more than one grant, contract, loan, or loan guarantee under this title, simultaneously or over the course of time, shall not be required to submit duplicate or redundant information but shall be required to update the specifications (required by paragraph (3)) respecting the existing or proposed health maintenance organization in such manner and with such frequency as the Secretary may by regulation prescribe. In determining, for purposes of paragraph (2), whether an applicant would be able to complete a project or undertaking without the assistance applied for, the Secretary shall not consider any asset of the applicant the obligation of which for such undertaking or project would jeopardize the fiscal soundness of the applicant.

[(c) The Secretary shall by regulation establish standards and procedures for health systems agencies to follow in reviewing and commenting on applications for grants, contracts, loans, and loan guarantees under this title.]

*(1) in the case of an application for assistance under section 1303 or 1304, such application meets the application requirements of such section and section 1307;*

*(2) in the case of an application for assistance under section 1303 or 1304, he determines that the applicant making the application would not be able to complete the project or undertaking for which the application is submitted without the assistance applied for;*

*(3) the application contains satisfactory specification of the existing or anticipated (A) population group or groups to be served by the proposed or existing health maintenance organization described in the application, (B) membership of such organization, (C) methods, terms, and periods of the enrollment of members of such organization, (D) estimated costs per member of the health services to be provided by such organization and the nature of such costs, (E) sources of professional services for such organization, and organizational arrangements of such organization for providing health services, (F) sources of prepayment and other forms of payment for the services to be provided by such organization, (G) facilities, and additional capital investments and sources of financing therefor, available to such organization to provide the level and scope of services proposed, (H) administrative, managerial, and financial arrangements and capabilities of such organization, (I) role for members in the planning and policymaking for such organization, (J) grievance procedures for members of such organization, (K) organizational arrangements of such organization for an ongoing quality assurance program in accordance with the requirements of section 1301(c)(9), and (L) evaluations of the support for and acceptance of such organization by the population to be served, the sources of operating support, and the professional groups to be involved or affected thereby;*

*(4) contains or is supported by assurances satisfactory to the Secretary that the applicant making the application will, in ac-*

*cordance with such criteria as the Secretary shall by regulation prescribe, enroll, and maintain an enrollment of the maximum number of members that its available and potential resources (as determined under regulations of the Secretary) will enable it to effectively serve;*

*(5) in the case of an application made for a project which previously received a grant, contract, loan, or loan guarantee under this title, such application contains or is supported by assurances satisfactory to the Secretary that the applicant making the application has the financial capability to adequately carry out the purposes of such project and has developed and operated such project in accordance with the requirements of this title and with the plans contained in previous applications for such assistance; and*

*(6) the application is submitted in such form and manner, and contains such additional information, as the Secretary shall prescribe in regulations.*

*An organization making multiple applications for more than one grant, contract, loan, or loan guarantee under this title, simultaneously or over the course of time, shall not be required to submit duplicate or redundant information but shall be required to update the specifications (required by paragraph (3)) respecting the existing or proposed health maintenance organization in such manner and with such frequency as the Secretary may by regulation prescribe. In determining, for purposes of paragraph (2), whether an applicant would be able to complete a project or undertaking without the assistance applied for, the Secretary shall not consider any asset of the applicant the obligation of which for such undertaking or project would jeopardize the fiscal soundness of the applicant.*

*(c) Upon denial of an application by an entity for designation as a 'qualified health maintenance organization' (as defined in section 1309(d)), the Secretary shall, within a reasonable time as established in regulations, give written notification to the entity making such application of the reasons for denial and shall provide the entity a reasonable opportunity for reconsideration of such determination including, at the entity's election, a fair hearing.*

ADMINISTRATION OF ASSISTANCE PROGRAMS

[SEC. 1307.] *SEC. 1306.* (a) (1) Each recipient of a [grant, contract, loan,] *loan* or loan guarantee under this title shall keep such records as the Secretary shall prescribe, including records which fully disclose the amount and disposition by such recipient of the proceeds of the [grant, contract, or] loan (directly made or guaranteed), the total cost of the undertaking in connection with which [such assistance] *the loan* was given or used, the amount of that portion of the cost of the undertaking supplied by other sources, and such other records as will facilitate an effective audit.

[(2) The Secretary, or any of his duly authorized representatives, shall have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients of a grant, contract, loan, or loan guarantee under this title which relate to such assistance.]

*(2) The Secretary, or any of his duly authorized representatives, shall at reasonable times, and upon written request which gives reasonable notice and includes a specific statement of the reasons for such request, have access for the purpose of audit and examination to any books, documents, papers, and records of the recipients of a loan or loan guarantee under this title which relate to such assistance.*

(b) Upon expiration of the period for which a [grant, contract, loan,] *loan* or loan guarantee was provided an entity under this title, such entity shall make a full and complete report to the Secretary in such manner as he may by regulation prescribe. Each such report shall contain, among such other matters as the Secretary may by regulation require, descriptions of plans, developments, and operations relating to the matters referred to in section [1306(b)(3).] *1305(b)(3).*

[(c) If in any fiscal year the funds appropriated under section 1309 are insufficient to fund all applications approved under this title for that fiscal year, the Secretary shall, after applying the applicable priorities under sections 1303 and 1304, give priority to the funding of applications for projects which the Secretary determines are the most likely to be economically viable.

[(d) An entity which provides health services to a defined population on a prepaid basis and which has members who are entitled to insurance benefits under title XVIII of the Social Security Act or to medical assistance under a State plan approved under title XIX of such Act may be considered as a health maintenance organization for purposes of receiving assistance under this title if—

[(1) with respect to its members who are entitled to such insurance benefits or to such medical assistance it (A) provides health services in accordance with section 1301(b), except that (i) it does not furnish to those members the health services (within the basic health services) for which it may not be compensated under such title XVIII or such State plan, and (ii) it does not fix the basic or supplemental health services payment for such members under a community rating system, and (B) is organized and operated in the manner prescribed by section 1301(c), except that it does not assume full financial risk on a prospective basis for the provision to such members of basic or supplemental health services with respect to which it is not required under such title XVIII or such State plan to assume such financial risk; and

[(2) with respect to its other members it provides health services in accordance with section 1301(b) and is organized and operated in the manner prescribed by section 1301(c).]

*(c) An entity which provides health services to a defined population on a prepaid basis and which has members who are entitled to insurance benefits under title XVIII of the Social Security Act or to medical assistance under a State plan approved under title XIX of such Act may be considered as a health maintenance organization for purposes of receiving assistance under this title if—*

*(1) with respect to its members who are entitled to such insurance benefits or to such medical assistance it (A) provides health services in accordance with section 1301(b), except that it does not furnish to those members the health services (within the basic health services) for which it may not be compensated under*

*such title XVIII or such State plan, and (B) is organized and operated in the manner prescribed by section 1301(c), except that it does not assume full financial risk on a prospective basis for the provision to such members of basic or supplemental health services with respect to which it is not required under such title XVIII or such State plan to assume such financial risk; and*

*(2) with respect to its other members it provides health services in accordance with section 1301(b) and is organized and operated in the manner prescribed by section 1301(c).*

An entity which provides health services to a defined population on a prepaid basis and which has members who are enrolled under the health benefits program authorized by chapter 89 of title 5, United States Code, may be considered as a health maintenance organization for purposes of receiving assistance under this title if with respect to its other members it provides health services in accordance with section 1301(b) and is organized and operated in the manner prescribed by section 1301(c).

[(e) In any fiscal year no loan guarantee may be made for a private health maintenance organization (other than a private nonprofit health maintenance organization) under this title if the making of such guarantee would cause the cumulative total of the principal of the loans guaranteed; for private health maintenance organizations (other than private nonprofit health maintenance organizations) under this title in such fiscal year to exceed the amount of grant and contract funds obligated under this title in such fiscal year; except that this subsection shall not apply if the amount of grant and contract funds obligated under this title in such fiscal year equals the sums appropriated under section 1309 for grants and contracts for such fiscal year.]

GENERAL PROVISIONS RELATING TO LOAN GUARANTEES AND LOANS

[SEC. 1308.] *SEC. 1307.* (a) (1) The Secretary may not approve an application for a loan guarantee under this title unless he determines that (A) the terms, conditions, security (if any), and schedule and amount of repayments with respect to the loan are sufficien to protect the financial interests of the United States and are otherwise reasonable, including a determination that the rate of interest does not exceed such per centum per annum on the principal obligation outstanding as the Secretary determines to be reasonable, taking into account the range of interest rates prevailing in the private market for loans with similar maturities, terms, conditions, and security and the risks assumed by the United States, and (B) the loan would not be available on reasonable terms and conditions without the guarantee under this title.

(2) (A) The United States shall be entitled to recover from the applicant for a loan guarantee under this title the amount of any payment made pursuant to such guarantee, unless the Secretary for good cause waives such right of recovery; and, upon making any such payment, the United States shall be subrogated to all of the rights of the recipient of the payments with respect to which the guarantee was made.

(B) To the extent permitted by subparagraph (C), any terms and conditions applicable to a loan guarantee under this title (including terms and conditions imposed under subparagraph (D)) may be modified by the Secretary to the extent he determines it to be consistent with the financial interest of the United States.

(C) Any loan guarantee made by the Secretary under this title shall be incontestable (i) in the hands of an applicant on whose behalf such guarantee is made unless the applicant engaged in fraud or misrepresentation in securing such guarantee, and (ii) as to any person (or his successor in interest) who makes or contracts to make a loan to such applicant in reliance thereon unless such person (or his successor in interest) engaged in fraud or misrepresentation in making or contracting to make such loan.

(D) guarantees of loans under this title shall be subject to such further terms and conditions as the Secretary determines to be necessary to assure that the purposes of this title will be achieved.

(b) (1) The Secretary may not approve an application for a loan under this title unless—

(A) the Secretary is reasonably satisfied that the applicant therefor will be able to make payments of principal and interest thereon when due, and

(B) the applicant provides the Secretary with reasonable assurances that there will be available to it such additional funds as may be necessary to complete the project or undertaking with respect to which such loan is requested.

(2) Any loan made under this title shall (A) have such security, (B) have such maturity date, (C) be repayable in such installments, (D) *initially* bear interest at a rate comparable to the current rate of interest prevailing, on the date the loan is made, with respect to marketable obligations of the United States of comparable maturities, adjusted to provide for appropriate administrative charges, *and which may be varied from time to time to reflect changes in the rate of interest prevailing with respect to such marketable obligations*, and (E) be subject to such other terms and conditions (including provisions for recovery in case of default), as the Secretary determines to be necessary to carry out the purposes of this title while adequately protecting the financial interests of the United States.

(3) The Secretary may, for good cause but with due regard to the financial interests of the United States, waive any right of recovery which he has by reason of the failure of a borrower to make payments of principal of and interest on a loan made under this title, except that if such loan is sold and guaranteed, any such waiver shall have no effect upon the Secretary's guarantee of timely payment of principal and interest.

(c) (1) The Secretary may from time to time, but with due regard to the financial interests of the United States, sell loans made by him under this title.

(2) The Secretary may agree, prior to his sale of any such loan, to guarantee to the purchaser (and any successor in interest of the purchaser) compliance by the borrower with the terms and conditions of such loan. Any such agreement shall contain such terms and conditions as the Secretary considers necessary to protect the financial interests

of the United States or as otherwise appropriate. Any such agreement may (A) provide that the Secretary shall act as agent of any such purchaser for the purpose of collecting from the borrower to which such loan was made and paying over to such purchaser, any payments of principal and interest payable by such organization under such loan; and (B) provide for the repurchase by the Secretary of any such loan on such terms and conditions as may be specified in the agreement. The full faith and credit of the United States is pledged to the payment of all amounts which may be required to be paid under any guarantee under this paragraph.

(3) After any loan under this title to a public health maintenance organization has been sold and guaranteed under this subsection, interest paid on such loan which is received by the purchaser thereof (or his successor in interest) shall be included in the gross income of the purchaser of the loan (or his successor in interest) for the purpose of chapter 1 of the Internal Revenue Code of 1954.

(4) Amounts received by the Secretary as proceeds from the sale of loans under this subsection shall be deposited in the loan fund established under section (e).

(5) Any reference in this title (other than in this subsection and in subsection (d)) to a loan guarantee under this title does not include a loan guarantee made under this subsection.

(d)(1) There is established in the Treasury a loan guarantee fund (hereinafter in this subsection referred to as the "fund") which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts, to enable him to discharge his responsibilities under loan guarantees issued by him under this title and to take the action authorized by subsection (f). There are authorized to be appropriated from time to time such amounts as may be necessary to provide the sums required for the fund. To the extent authorized in appropriation Acts, there shall also be deposited in the fund amounts received by the Secretary in connection with loan guarantees under this title and other property or assets derived by him from his operations respecting such loan guarantees, including any money derived from the sale of assets.

(2) If at any time the sums in the funds are insufficient to enable the Secretary to discharge his responsibilities under guarantees issued by him under this title and to take the action authorized by subsection (f), he is authorized to issue to the Secretary of the Treasury notes or other obligations in such forms and denominations, bearing such maturities, and subject to such terms and conditions, as may be prescribed by the Secretary with the approval of the Secretary of Treasury. Such notes or other obligations shall bear interest at a rate determined by the Secretary of the Treasury, taking into consideration the current average market yield on outstanding marketable obligations of the United States of comparable maturities during the month preceding the isuance of the notes or other obligations. The Secretary of the Treasury shall purchase any notes and other obligations issued under this paragraph and for that purpose he may use as a public debt transaction the proceeds from the sale of any securities issued under the Second Liberty Bond Act, and the purposes for which the securities may be issued under that Act are extended to include any

purchase of such notes and obligations. The Secretary of the Treasury may at any time sell any of the notes or other obligations acquired by him under this pargraph. All redemptions, purchases, and sales by the Secretary of the Treasury of such notes or other obligations shall be treated as public debt transactions of the United States. Sums borrowed under this paragraph shall be deposited in the fund and redemption of such notes and obligations shall be made by the Secretary from the fund.

(e) There is established in the Treasury a loan fund (hereinafter in this subsection referred to as the 'fund") which shall be available to the Secretary without fiscal year limitation, in such amounts as may be specified from time to time in appropriation Acts, to enable him to make loans under this title and to take the action authorized by subsection (f). There shall also be deposited in the fund amounts received by the Secretary as interest payments and repayment of principal on loans made under this title and other property or assets derived by him from his operations respecting such loans, from the sale of loans under subsection (c) of this section, or from the sale of assets.

(f) The Secretary may take such action as he deems appropriate to protect the interest of the United States in the event of a default on a loan made or guaranteed under this tile, including taking possession of, holding, and using real property pledged as security for such a loan or loan guarantee.

*(g) The Secretary may from time to time deposit into the miscellaneous receipts of the Treausry from the funds established under subsections (d) and (e) amounts that he finds are not needed to accomplish the purposes of those funds.*

[SEC. 1309. (a) For the purpose of making payments under grants and contracts under sections 1303, 1304(a), 1304(b), and 1317, there are authorized to be appropriated $25,000,000 for the fiscal year ending June 30, 1974, $55,000,000 for the fiscal year ending June 30, 1975, $40,000,000 for the fiscal year ending June 30, 1976, $45,000,000 for the fiscal year ending September 30, 1977, $45,000,000 for the fiscal year ending September 30, 1978, $31,000,000 for the fiscal year ending September 30, 1979, $65,000,000 for the fiscal year ending September 30, 1980, and $68,000,000 for the fiscal year ending September 30, 1981.

[(b) There is authorized to be appropriated to the loan fund established under section 1308(a) $75,000,000 in the aggregate for the fiscal years ending June 30, 1974, and June 30, 1975.]

*SEC. 1308. (a) For the purpose of carrying out section 1312, there are authorized to be appropriated $1,000,000 for the fiscal year ending September 30, 1982, and for each of the two succeeding fiscal years.*

*(b) There is authorized to be appropriated to the loan fund established under section 1307(e) $35,000,000 in the aggregate for the fiscal years ending after September 30, 1981.*

*(c) Except as provided in subsection (a) or subsection (b) there are authorized to be appropriated for grants and contract under this title $15,000,000 in the aggregate for the fiscal years ending September 30, 1982, September 30, 1983, and September 30, 1984. No funds appropriated under this subsection may be expended or obligated for a grant or contract unless the entity received a grant or contract under this title during or prior to the fiscal year ending September 30, 1981.*

[SEC. 1310.] *Sec. 1309.* (a)(1). In accordance with regulations which the Secretary shall prescribe—

(A) each employer—

(i) which is now or hereafter required during any calendar quarter to pay its employees the minimum wage prescribed by section 6 of the Fair Labor Standards Act of 1938 (or would be required to pay its employees such wage but for section 13(a) of such Act), and

(ii) which during such calendar quarter employed an average number of employees of not less than 25,

shall include in any health benefits plan, and

(B) any State and each political subdivision therof which during any calendar quarter employed an average number of employees of not less than 25, as a condition of payment to the State of funds under section 314(d), 317, 318, 1002, 1525, or 1613, shall include in any health benefits plan,

offered to such employees in the calendar year beginning after such calendar quarter the option of membership in qualified health maintenance organizations which are engaged in the provision of basic health services in health maintenance organization service areas in which at least 25 of such employees reside.

(2) If any of the employees of an employer or State or political subdivision thereof described in paragraph (1) are represented by a collective bargaining representative or other employee representative designated or selected under any law, offer of membership in a qualified health maintenance organization required by paragraph (1) to be made in a health benefits plan offered to such employees (A) shall first be made to such collective bargaining representative or other employee representative, and (B) if such offer is accepted by such representative, shall then be made to each such employee.

(b) If there is more than one qualified health maintenance organization which is engaged in the provision of basic and supplemental health services in the area in which the employees of an employer subject to subsection (a) reside and if—

(1) one or more of such organizations provides basic health services through physicians or other health professionals who are members of the staff of the organization or a medical group (or groups), and

(2) one or more of such organizations provides basic health services through (A) an individual practice association (or associations), or (B) [a combination of such association (or associations), medical group (or groups), staff, and] individual physicians and other health professionals under contract with the organization, *or (C) a combination of such association (or associations), medical group (or groups), staff, and individual physicians and other health professionals under contract with the organization,*

then of the qualified health maintenance organizations included in a health benefits plan of such employer pursuant to subsection (a) at least one shall be an organization which provides basic health

services as described in clause (1) and at least one shall be an organization which provides basic health services as described in clause (2).

(c) No employer shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other legally enforceable contract for the provision of health benefits between the employer and its employees. Each employer which provides payroll deductions as a means of paying employees' contributions for health benefits or which provides a health benefits plan to which an employee contribution is not required and which is required by subsection (a) to offer his employees the option of membership in a qualified health maintenance organization shall, with the consent of an employee who exercises such option, arrange for the employee's contribution for such membership to be paid through payroll deductions.

[(d) For purposes of this section, the term "qualified health maintenance organization" means (1) a health maintenance organization which has provided assurances satisfactory to the Secretary that it provides basic and supplemental health services to its members in the manner prescribed by section 1301(b) and that it is organized and operated in the manner prescribed by section 1301(c), and (2) an entity which proposes to become a health maintenance organization and which the Secretary determines will when it becomes operational provide basic and supplemental health services to its members in the manner prescribed by section 1301(b) and will be organized and operated in the manner prescribed by section 1301(c).]

*(d) For purposes of this section, the term "qualified health maintenance organization" means (1) a health maintenance organization under the terms of this title, and (2) an entity which proposes to become a health maintenance organization and which the Secretary determines will when it becomes operational provide basic and supplemental health services to its members in the manner prescribed by section 1301(b) and will be organized and operated in the manner prescribed by section 1301(c): Provided, however, That every health maintenance organization must, at its own expense, demonstrate to the Secretary every two years (or such longer period as the Secretary may, by regulation, require), that such organization is qualified under this title.*

(e)(1) Any employer who knowingly does not comply with one or more of the requirements of subsection (a), (b) or (c) shall be subject to a civil penalty of not more than $10,000. If such noncompliance continues, a civil penalty may be assessed and collected under this subsection for each thirty-day period such noncompliance continues. Such penalty may be assessed by the Secretary and collected in a civil action brought by the United States in a United States district court.

(2) In any proceeding by the Secretary to assess a civil penalty under this subsection, no penalty shall be assessed until the employer charged shall have been given notice and an opportunity to present its views on such charge. In deermining the amount of the

penalty, or the amount agreed upon in compromise, the Secretary shall consider the gravity of the noncompliance and the demonstrated good faith of the employer charged in attempting to achieve rapid compliance after notification by the Secretary of a noncompliance.

(3) In any civil action brought to review the assessment of a civil penalty assessed under this subsection, the court shall, at the request of any party to such action, hold a trial de novo on the assessment of such civil penalty and in any civil action to collect such a civil penalty, the court shall, at the request of any party to such action, hold a trial de novo on the assessment of such civil penalty unless in a prior civil action to review the assessment of such penalty the court held a trial de novo on such assessment.

(f) For purposes of this section, the term "employer" does not include (1) the Government of the United States, the government of the District of Columbia or any territory or possession of the United States, a State or any political subdivision thereof, or any agency or instrumentality (including the United States Postal Service and Postal Rate Commission) of any of the foregoing; or (2) a church, convention or association of churches, or any organization operated, supervised or controlled by a church, convention or association of churches which organization (A) is an organization described in section 501(c)(3) of the Internal Revenue Code of 1954, and (B) does not discriminate (i) in the employment, compensation, promotion, or termination of employment of any personnel, or (ii) in the extension of staff or other privileges to any physician or other health personnel, because such persons seek to obtain or obtained health care, or participate in providing health care, through a health maintenance organization.

(g) If the Secretary, after reasonable notice and opportunity for hearing to a State, finds that [it] *the State* or any of its political subdivisions has failed to comply with one or more of the requirements of subsection (a), the Secretary shall terminate payments to such State under sections 314(d), 317, 318, 1002, 1525, and 1613 and notify the Governor of such State that further payments under such sections will not be made to the State until the Secretary is satisfied that there will no longer be any such failure to comply.

RESTRICTIVE STATE LAWS AND PRACTICES

[SEC. 1311.] *Sec. 1310.* (a) In the case of any entity—

(1) which cannot do business as a health maintenance organization in a State in which it proposes to furnish basic and supplemental health services because that State by law, regulation, or otherwise—

(A) requires as a condition to doing business in that State that a medical society approve the furnishing of services by the entity,

(B) requires that physicians constitute all or a percentage of its governing body,

(C) requires that all physicians or a percentage of physicians in the locale participate or be permitted to participate in the provision of services for the entity, or

(D) requires that the entity meet requirements for insurers of health care services doing business in that State respecting initial capitalization and establishment of financial reserves against insolvency, and

(2) for which a [grant, contract, loan,] *loan* or loan guarantee was made under this title or which is a qualified health maintenance organization for purposes of section [1310] *1309* relating to employees' health benefits plans),

such requirements shall not apply to that entity so as to prevent it from operating as a health maintenance organization in accordance with section 1301.

(b) No State may establish or enforce any law which prevents a health maintenance organization for which a [grant, contract, loan,] *loan* or loan guarantee was made under this title or which is a qualified health maintenance organization for purposes of section [1310] *1309* (relating to employees' health benefits plans), from soliciting members through advertising its services, charges, or other nonprofessional aspects of its operation. This subsection does not authorize any advertising which identifies, refers to, or makes any qualitative judgment concerning, any health professional who provides services for a health maintenance organization.

[(c) The Secretary shall, within 6 months after the date of the enactment of this subsection, develop a digest of State laws, regulations, and practices pertaining to development, establishment, and operation of health maintenance organizations which shall be updated at least quarterly and relevant sections of which shall be provided to the Governor of each State annually. Such digest shall indicate which State laws, regulations, and practices appear to be inconsistent with the operation of this section. The Secretary shall also insure that appropriate legal consultative assistance is available to the States for the purposes of complying with the provisions of this section.]

CONTINUED REGULATION OF HEALTH MAINTENANCE ORGANIZATIONS

[SEC. 1312.] *Sec. 1311.* (a) If the Secretary determines that an entity which received a [grant, contract, loan,] *loan* or loan guarantee under this title as a health maintenance organization or which was included in a health benefits plan offered to employees pursuant to section [1310—] *1309*—

(1) fails to provide basic and supplemental services to its members,

(2) fails to provide such services in the manner prescribed by section 1301(b), or

(3) is not organized or operated in the manner prescribed by section 1301(c),

the Secretary may take the action authorized by subsection (b).

(b)(1) If the Secretary makes, with respect to any [entity which provided assurances to the Secretary] *health maintenance organization as defined* under section 1310(d)(1), a determination described in subsection (a), the Secretary shall notify the entity in writing of the determination. Such notice shall specify the manner in which the entity has not complied with such assurances and direct that the entity

initiate (within 30 days of the date the notice is issued by the Secretary or within such longer period as the Secretary determines is reasonable) such action as may be necessary to bring (within such period as the Secretary shall prescribe) the entity into compliance with the assurances. If the entity fails to initiate corrective action within the period prescribed by the notice or fails to comply with the assurances within such period as the Secretary [prescribes] *prescribes, then after the Secretary provides the entity a reasonable opportunity for reconsideration of his determination, including, at the entity's election, a fair hearing,* (A) the entity shall not be a qualified health maintenance organization for purposes of section [1310] *1309* until such date as the Secretary determines that it is in compliance with the assurances, and (B) each employer which has offered membership in the entity in compliance with section [1310,] *1309*, each lawfully recognized collective bargaining representative or other employee representative which represents the employees of each such employer, and the members of such entity shall be notified by the entity that the entity is not a qualified health maintenance organization for purposes of such section. The notice required by clause (B) of the preceding sentence shall contain, in readily understandable language, the reasons for the determination that the entity is not a qualified health maintenance organization. The Secretary shall publish in the Federal Register each determination referred to in this paragraph.

(2) If the Secretary makes with respect to an entity which has received a [grant, contract,] loan, or loan guarantee under this title, a determination described in subsection (a), the Secretary may, in addition to any other remedies available to him, bring a civil action in the United States district court for the district in which such entity is located to enforce its compliance with the assurances it furnished respecting the provision of basic and supplemental health services or its organization or operation, as the case may be, which assurances were made in connection with its application under this title for the [grant, contract, loan,] *loan* or loan guarantee.

*(c) The Secretary may delegate to a State any or all of his responsibilities under subsection (a) and (b)(1) with respect to entities in that State, but only to the extent that the Secretary finds that the State is able and willing to carry out those responsibilities.*

[LIMITATION ON SOURCE OF FUNDING FOR HEALTH MAINTENANCE ORGANIZATIONS

[SEC. 1313. No funds appropriated under any provision of this Act (except as provided in sections 329, 330, and 340) other than this title may be used—

[(1) for grants or contracts for surveys or other activities to determine the feasibility of developing or expanding health maintenance organizations or other entities which provide, directly or indirectly, health services to a defined population on a prepaid basis;

[(2) for grants or contracts, or for payments under loan guarantees, for planning projects for the establishment or expansion of such organizations or entities;

[(3) for grants or contracts, or for payments under loan guarantees, for projects for the initial development or expansion of such organizations or entities; or

[(4) for loans, or for payments under loan guarantees, to assist in meeting the costs of the initial operation after establishment or expansion of such organizations or entities or in meeting the costs of such organizations in acquiring or constructing ambulatory health care facilities.

[PROGRAM EVALUATION

[SEC. 1314. (a) The Comptroller General shall evaluate the operations of at least ten or one-half (whichever is greater) of the health maintenance organizations for which assistance was provided under sections 1303, 1304, and 1305, and which, by December 31, 1976, have been designated by the Secretary under section 1310(d) as qualified health maintenance organizations. The Comptroller General shall report to the Congress the results of the evaluation by June 30, 1978. Such report shall contain findings—

[(1) with respect to the ability of the organizations evaluated to operate on a fiscally sound basis without continued Federal financial assistance,

[(2) with respect to the ability of such organizations to meet the requirements of section 1301(c) respecting their organization and operation,

[(3) with respect to the ability of such organizations to provide basic and supplemental health services in the manner prescribed by section 1301(b),

[(4) with respect to the ability of such organizations to include indigent and high-risk individuals in their membership, and

[(5) with respect to the ability of such organizations to provide services to medically underserved populations.

[(b) The Comptroller General shall also conduct a study of the economic effects on employers resulting from their compliance with the requirements of section 1310. The Comptroller General shall report to the Congress the results of such study not later than thirty-six months after the date of the enactment of this title.

[(c) The Comptroller General shall evaluate (1) the operations of distinct categories of health maintenance organizations in comparison with each other, (2) health maintenance organizations as a group in comparison with alternative forms of health care delivery, and (3) the impact that health maintenance organizations, individually, by category, and as a group, have on the health of the public. The Comptroller General shall report to the Congress the results of such evaluation not later than thirty-six months after the date of the enactment of this title.

[(d) The Comptroller General shall evaluate the adequacy and effectiveness of the policies and procedures of the Secretary for the management of the grant and loan programs established by this title and the adequacy of the amounts of assistance available under such programs and shall report to the Congress the results of such evaluation not later than May 1, 1979.

[ANNUAL REPORT

[SEC. 1315. (a) The Secretary shall periodically review the programs of assistance authorized by this title and make an annual report to the Congress of a summary of the activities under each program. The Secretary shall include in such summary—

[(1) a summary of each grant, contract, loan, or loan guarantee made under this title in the period covered by the report and a list of the health maintenance organizations which during such period became qualified health maintenance organizations for purposes of section 1310;

[(2) the statistics and other information reported in such period to the Secretary in accordance with section 1301(c)(11);

[(3) findings with respect to the ability of the health maintenance organizations assisted under this title—

[(A) to operate on a fiscally sound basis without continued Federal financial assistance,

[(B) to meet the requirements of section 1301(c) respecting their organization and operation,

[(C) to provide basic and supplemental health services in the manner prescribed by section 1301(b),

[(D) to include indigent and high-risk individuals in their membership, and

[(E) to provide services to medically underserved populations; and

[(4) findings with respect to—

[(A) the operation of distinct categories of health maintenance organizations in comparison with each other,

[(B) health maintenance organizations as a group in comparison with alternative forms of health care delivery, and

[(C) the impact that health maintenance organizations, individually, by category, and as a group, have on the health of the public.

[(b) The Office of Management and Budget may review the Secretary's report under subsection (a) before its submission to the Congress, but the Office may not revise the report or delay its submission, and it may submit to the Congress its comments (and those of other departments or agencies of the Government) respecting such report.

[ADMINISTRATION OF PROGRAM

[SEC. 1316. The Secretary shall administer this title (other than sections 1310 and 1312) through a single identifiable administrative unit of the Department.]

TRAINING AND TECHNICAL ASSSTANCE

[SEC. 1317.] *SEC. 1312* (a)(1) The Secretary shall establish a National Health Maintenance Organization Intern Program (hereinafter in this subsection referred to as the "Program") for the purpose of providing training to individuals to become administrators and medical directors of health maintenance organizations or to assume other managerial positions with health maintenance organiza-

tions. Under the Program the Secretary may directly provide internships for such training and may make grants to or enter into contracts with health maintenance organizations and other entities to provide such internships.

(2) No internship may be provided by the Secretary and no grant may be made or contract entered into by the Secretary for the provision of internships unless an application therefor has been submitted to and approved by the Secretary. Such an application shall be in such form and contain such information, and be submitted to the Secretary in such manner, as the Secretary shall prescribe. [Section 1306 does not apply to an application submitted under this section.]

(3) Internships under the Program shall provide for such stipends and allowances (including travel and subsistence expenses and dependency allowances) for the recipients of the internships as the Secretary deems necessary. An internship provided an individual for training at a health maintenance organization or any other entity shall also provide for payments to be made to the organization or other entity for the cost of support services (including the cost of salaries, supplies, equipment, and related items) provided such individual by such organization or other entity. The amount of any such payments to any organization or other entity shall be determined by the Secretary and shall bear a direct relationship to the reasonable costs of the organization or other entity for establishing and maintaining its training programs.

(4) Payments under grants under the Program may be made in advance or by way of reimbursement, and at such intervals and on such conditions, as the Secretary finds necessary.

(b) The Secretary shall provide technical assistance (1) to entities in connection with projects for which [assistance is] *loans are* being provided under section [1303 or] 1304, (2) to entities intending to become a qualified health maintenance organization within the meaning of section [1310(d),] and *1309(d)*, and (3) to health maintenance organizations. The Secretary may provide such technical assistance through grants to public and nonprofit private entities and contracts with public and private entities.

(c) The authority of the Secretary to enter into contracts under subsections (a) and (b) shall be effective for any fiscal year only to such extent or in such amounts as are provided in advance by appropriation Acts.

FINANCIAL DISCLOSURE

[SEC. 1318.] *SEC. 1313.* (a) Each health maintenance organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

(1) Such information as the Secretary [may require demonstrating] *determines is necessary to demonstrate* that the health maintenance organization has a fiscally sound operation.

(2) The information required to be reported under section 1124 of the Social Security Act by disclosing entities and the information required to be supplied under section 1902(a)(38) of such Act.

(3) A description of transactions, as specified by the Secretary, between the health maintenance organization and a party in interest. Such transactions shall include—

(A) any sale or exchange, or leasing of any property between the health maintenance organization and a party in interest;

(B) any furnishing for consideration of goods, services (including management services, but excluding health services provided to members by staff, medical group (or groups), individual practice association (or associations), or any combination thereof), or facilities between the health maintenance organization and a party in interest; and

(C) any lending of money or other extension of credit between a health maintenance organization and a party in interest.

The Secretary may require that information reported respecting a health maintenance organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(b) For the purposes of this section the term "party in interest" means:

(1) any director, officer, partner, or employee of a health maintenance organization, any person who is directly or indirectly the beneficial owner of more than 5 per centum of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 per centum of the health maintenance organization, and, in the case of a health maintenance organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

(2) any entity in which a person described in paragraph (1)—

(A) is an officer or director;

(B) is a partner (if such entity is organized as a partnership);

(C) has directly or indirectly a beneficial interest of more than 5 per centum of the equity; or

(D) has a mortgage, deed of trust, note, on other interest valuing more than 5 per centum of the assets of such entity;

(3) any person directly or indirectly controlling, controlled by, or under common control with a health maintenance organization; and

(4) any member of the immediate family of an individual described in paragraph (1).

(c) Each health maintenance organization shall make the information reported pursuant to subsection (a) available to its enrollees upon reasonable request.

(d) The Secretary shall, as he deems necessary, conduct an evaluation of transactions reported to the Secretary under subsection (a) (3) for the purpose of determining their adverse impact, if any, on the fiscal soundness and reasonableness of charges to the health maintenance organization with respect to which they transpired. The Secretary shall evaluate the reported transactions of not less than five, or if

there are more than twenty health maintenance organizations reporting such transactions, not less than one-fourth of the health maintenance organizations reporting any such transactions under subsection (a)(3).

(e) The Secretary shall file an annual report with the Congress on the operation of this section. Such report shall include—

(1) an enumeration of standards and norms utilized to make the evaluations required under subsection (d);

(2) an assessment of the degree of conformity or nonconformity of each health maintenance organization evaluated by the Secretary under subsection (d) with such standards and norms; and

(3) what action, if any, the Secretary considers necessary under section 1312 with respect to health maintenance organizations evaluated under subsection (d).

(f) Nothing in this section shall be construed to confer upon the Secretary any authority to approve or disapprove the rates charged by any health maintenance organization.

(g) Any health maintenance organization failing to file with the Secretary the annual financial statement required in subsection (a) shall be ineligible for any Federal assistance under this title until such time as such statement is received by the Secretary and shall not be a qualified health maintenance organization for purposes of section [1310.] *1309.*

(h) Whoever knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any statement filed pursuant to this section shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

*LIMITATIONS ON LOANS AND CONTRACTS*

*Sec. 1314. The Secretary may make loans and enter into contracts under this title only to such extent or in such amounts as are provided in appropriation Acts.*

Sec. 3. This Act shall take effect on October 1, 1981.

## X. ADDITIONAL VIEWS

We are gratified that the Committee, in its consideration of this important legislation to extend the HMO Act, has made a number of significant improvements to S. 1029 that ensure the orderly and sound development of HMOs in the United States. The integrity of the basic benefit package has been restored, dual choice has been preserved, quality assurance and protections against fraud and abuse returned to existing law, and the important principle of consumer representation in HMO policymaking maintained. The Commitee has agreed to provide $15 million for grants and contracts to HMOs now in the development process with federal financial assistance. Since, however, we believe that there are still several important defects in the bill as reported, we write separately to identify our remaining concerns.

The HMO concept is an important and powerful tool in the national effort to provide quality, cost-effective health care. Although HMOs are not a panacea, their continued development is essential to promoting prevention oriented, cost-conscious health care.

Since the original enactment of the HMO Act in 1973, the Federal government has played an important role in promoting the development of HMOs, through federal financial assistance and through "dual choice." This Federal support was extended out of a belief that the HMO approach to health care delivery offers an unparalleled opportunity to curb rising health care costs and to extend the benefits of comprehensive health care to broad segments of the public. To achieve these goals, it was apparent that HMOs must be more than pale imitations of the fee-for-service delivery system. Accordingly, the Act as written, and as subsequently amended, has set forth certain standards that an HMO must meet in order to qualify for federal financial support and for dual choice. These standards concern the structure of a qualifying HMO, quality assurance and fiscal integrity of the HMO's operations.

By all measures, the program has been a success. HMOs have demonstrated their ability to hold down health care costs by as much as 10 to 40 percent below the costs for persons enrolled under traditional health insurance plans. In the past ten years the number of HMOs has grown from 39 to 242; enrollment has nearly tripled. In Massachusetts, for example, HMO enrollment grew by over 10 percent from 1979 to 1980. Ninety-two HMOs that have received federal financial support are operational, while 80 additional HMOs are now in the development process with federal financial support.

The Committee has recognized the need to continue financial support for HMOs that are now in the development process. But the funds authorized are inadequate to permit all the HMOs in the pipeline to complete their development. Based on OHMO estimates, a total of nearly $40 million in grants and contracts would be needed

to fund the 66 HMOs that are currently at various stages of development. Without this support, these HMOs will either have to disband, or rely on the uncertain and speculative prospect of financial support from other sources to finish their development. We believe that the federal government has a strong interest in seeing through to completion these HMOs, and would accordingly provide the funds necessary to accomplish this objective.

The bill as reported would also phase-out federal loans and loan guarantees for HMOs. Although we support greater reliance on the private sector for financing HMOs, we believe that the federal government should continue to play a back-up role in assuring the availability of capital to HMOs. HMOs, by their nature, have difficulty in attracting private investment in their early stages, due to the lack of collateral to secure loans and the relatively long period between start-up and break even. Experience has demonstrated that with assistance at the early stages HMOs can become successful profitmaking ventures but that barriers to obtaining capital can seriously impede their development. We therefore suport maintaining a $5 million revolving loan fund, to be made available at market rates, for new loans to HMOs. If carefully administered, this program would be at little or no cost to the government.

The bill as reported also makes certain unwarranted changes in the standards for federal qualification of HMOs. First, the bill would eliminate the requirement that HMOs base their premiums on community rating, and instead would permit HMOs to experience rate—including rating based on the health, prior medical conditions and health care utilization of the enrollees.

We support giving HMOs additional flexibility in rating, and therefore proposed "class-based" rating, which would allow HMOs to rate on actuarial categories. But we believe that rating based on health and prior utilization is fundamentally contrary to the nature of HMOs. Although experience rating may permit HMOs to attract some additional subscribers by offering low premiums to healthy individuals, it will remove much of the risk-sharing that gives HMOs incentives to reduce health care costs for all subscribers, and may prove an insurmountable price barrier to enrollment in HMOs by those with poorer than average health. In many instances, the greatest potential for cost-savings through the HMO approach comes precisely with those who are relatively high users of health care.

The bill also eliminates the requirement that well-established, solvent HMOs offer open enrollment. Open enrollment is a cornerstone of HMOs potential contribution to competition-in-health care. Through open enrollment, the benefits of HMO membership are extended to all members of the community, fostering competition between HMOs and other insurance carriers. Dr. Alain Enthoven, a leading proponent of competition in health care, has identified open enrollment as one of the fundamental principles which must underlie a pro-competition approach.

The open enrollment requirement is quite limited in existing law; it applies only to fiscally solvent HMOs that have been operating as HMOs for at least 5 years or which have 50,000 members. Nonetheless, it is important reminder that if HMOs are to fulfill their promise

in promoting quality, cost-effective care, members of the community must have the opportunity to take advantage of the HMO approach.

We are also concerned by the elimination of the requirement that an HMO be a "separate entity" and not simply an operating arm of a larger entity.

Although we support providing HMOs additional design flexibility, we are concerned that companies that operate HMOs as a "line of business" in conjunction with more traditional forms of health insurance will have diminished incentives to assure that the HMO will grow and prosper. If such a provision is ultimately adopted, we believe it is essential that the Secretary of HHS closely monitor the performance of federally qualified, line of business HMOs to assure that they are a spur and not a barrier to effective competition in health care.

Finally, we take exception to the requirement of mandatory periodic recertification review. Although S. 1029 was promoted as eliminating unnecessary federal regulations, this provision would substantially increase the regulatory and paperwork burden on HMOs. Although we strongly support maintaining federal responsibility for assuring that federally qualified HMOs continue to meet the federal standards, the rigid periodic recertification procedure in the bill is cumbersome and unnecessary. By the same token, we disagree with providing authority for the Secretary to delegate this responsibility to the states. This provision raises the serious danger that a patchwork of varying requirements will develop from state to state, creating substantial uncertainty and formidable barriers to investments in HMOs. Federal qualification is a national concern which should be administered through clear and uniform federal oversight.

Edward M. Kennedy.
Jennings Randolph.
Harrison A. Williams, Jr.
Clairborne Pell.
Donald W. Riegle, Jr.

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